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SALEM TEEN MOTHER PROGRAM:

A FOLLOW-UP STUDY

by

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CHAPTER I

INTRODUCTION

Society has, historically, reacted to teenage pregnancies with a mixture of embarrassment, apathy and neglect. It wasn't until the 1960's that an attempt was made to design and implement programs to meet the needs of pregnant adolescents. An example of such a program is the Salem Teen Mother Program. This program was begun in 1966 and is affiliated with the local YWCA. If offers a comprehensive program to approximately 150 students each year. The services it offers include day care, social services and counseling, education, health services, parenting skills and employment counseling.

The Salem Teen Mother Program states its mission as follows:

> To decrease risk for the school-age mother and child, and to help the young women develop into socially mature and economically self-sufficient persons. (Salem Teen Mother Program statement.)

The program has endeavored through the years to improve the quality of its services so that it might offer young women every opportunity to continue their education and obtain their diploma or GED. Prenatal information and health services have been seen as desirable steps to the delivery of a healthy baby. Both the parenting skills class and the day care program attempt to prepare the majority of young women who opt to keep their child for the realities and frustrations of being a parent. The aim is a

healthy mother and a healthy child, physically and emotionally.

Data from the Teen Mother Program attest to the fact that most of their students elect to keep their child. Other realities that cannot be ignored are the need for a high school diploma, or its equivalency, and the value our society places on self-sufficiency as opposed to being a recipient of Welfare.

During 1979 the staff of the Teen Mother Program, in conjunction with a group of graduate students from Portland State University School of Social Work, planned a follow-up study of the young women who had graduated in the preceding four years. The purpose of this study was to determine the strengths and weaknesses of the program from the perspective of past students, and to see if some of the program's long range goals for students had been attained. The data, thus, would be used to improve services for present and future program participants.

The following chapters include a literature review which describes the problems facing teenage mothers in the nation. Programs that have been implemented to deal with those problems and the results of related research studies are also discussed. Subsequent chapters are devoted to the follow-up study of the Salem Teen Mother Program. First a description of the program is presented followed by chapters on methodology, data analysis, results and the conclusions from the study.

CHAPTER II

REVIEW OF THE LITERATURE

In seeking ways to improve services for teen parents, a major theme emerges: the problem of adolescent parenthood is a very complex one. After a period of apathy and neglect during the 40's and 50's, society responded to the needs of teen parents with a variety of programs. However, it was not easy within the context of other social issues and problems to find simple solutions. Indeed, solutions had to be multi-faceted and interrelated with other social service programs. Program developers were deeply interested in how resources and energy could be best utilized. Evaluation of programs and responding to findings could become the key to attacking the complexity. Then service providers can begin to answer what specific program elements can contribute most to the well-being of teen parents.

SCOPE OF THE PROGRAM

History

Teenage pregnancy is a phenomenon that this country has failed to address as a public issue until the last two decades. Rather, it was treated as a personal problem which was ignored and hidden by society except for scattered maternity homes (Murdock, 1968). Young women were usually expelled from school when it became apparent they were pregnant, so as not to negatively influ-

ence their classmates, or they dropped out to avoid embarrassment. Althouth home study and visiting teachers were provided in maternity homes during the 40's and 50's, these services were very inadequate and served only a small percentage of the school-age parents (Lyons, 1968). Among other alternatives were forced marriages which often didn't last; going out of town for the birth and releasing the child for adoption; illegal abortions; and single parenthood in the grandparent's household. Usually young fathers received no negative sanctions and society often blamed the young women for lack of mature judgment. Although there were viable alternatives for some young people, the experiences usually led to lifelong social and personal problems. Minority groups and the poor were especially vulnerable, as most maternity homes would not accept them, and they did not have the financial capability for other choices (Murdock, 1968).

Increasing Problem

What has awakened the public to this problem? First, the nation appears to be undergoing an epidemic of births to adolescents. Although the birth rate has actually decreased in recent years for adolescents aged 16-19, it has increased for those under age 16. Since the mid-1960's, the proportion of babies born to unwed teenage mothers has increased. Illegitimacy rates for teenagers aged 16-19 tripled between 1940 and 1975. In 1975 the illegitimacy rate for teenagers was 24.2 illegitimate births per 1,000 unmarried women, an increase of 59 percent since 1963. The illegitimacy rate leveled off between 1970 and 1972 but con-

tinued to rise gradually from 1972 to 1975 (Chilman, 1978). Although the overall U.S. fertility rate was decreasing, the number of teenage pregnancies steadily increased to over 1,000,000 in 1974, when 59 percent of the teenage pregnancies were live births, 27 percent were abortions, and 14 percent ended in miscarriages (Schinke, 1978). By 1976 the Guttmacher Institute (1976) labeled the problem an epidemic.

Social Changes

Secondly, other social realities brought the plight of the teenage parent to the public's attention. The migration from the rural south to the urban north made the problem more visible. No longer was the black, pregnant woman isolated on farms out of view of the social service agencies. The war on poverty also made the public more aware of the problem by increasing concern for the basic rights denied certain groups and especially the rights of women. School-age parents were certainly denied, among other rights, the basic right of all children: education. The increasing percentage of adolescent parents on Welfare rolls was another social reality causing public concern (Braen and Forbush, 1975).

Health of the Teen Mother and Her Infant

Thirdly, the public became aware that school-age parents were more likely to have medical problems. There is substantial evidence that the teenage mother and her infant are at risk medically. The Osofsky team (1973) cite 15 national and international studies that support this statement. Most authors have found significant increases in the incidences of excessive weight gain,

toxemia, fetal-pelvic disproportion, prolonged labor, prematurity and perinatal loss, and, in girls age 14 or less, increase in maternal loss.

Grant and Heald (1972) were able to show that while adolescents are a special high-risk group, race and socio-economic status were more important determinants of obstetric complications than age alone. However, regardless of race and socio-economic status, increased prematurity and higher neonatal death rates were found in girls under age 20 and these complications were even more prevalent in girls under 17 (Osofsky, Osofsky, Kendall and Rajan, 1973). Low birth weight has consistently been associated with teenage pregnancies and in 1967 mothers under age 15 giving birth to infants weighing less that 1500 gms was twice the national average (Osofsky et al., 1973).

Effect on Education

Fourth, teen mothers were also seen to be at risk educationally. School dropout has frequently been associated with teenage pregnancy (Bacon, 1974; Conger, 1973; Ewer and Gibb, 1976; LaBarre, 1972; and Sugar, 1976). Expelling the pregnant girl has been a common practice in schools in the past. At a time when school was the most important institution in their lives, they were forced from participating in it (Baizerman, Shehan, Ellison and Schlisinger, 1971; Chenoweth, 1971; Hoeft, 1968; Howard, 1968; Howard, 1970; Morgenthau, 1967; Wurtz and Fergen, 1970). Exclusion from school isolated the pregnant adolescent from her peers, from the educational system, and delayed early prenatal care (Howard, 1970.)

In some instances, the school system instituted special programs for the pregnant student. Some schools provided services under programs for the handicapped, the maladjusted, and the emotionally disturbed (Wurtz et al., 1970). Other schools provided home tutoring once each week, night classes or instruction within a building isolated from the main campus.

Often reentry into school after the girl had delivered was difficult if not impossible (Howard, 1968; Howard, 1970). Some schools imposed unreasonable lengths of time between the delivery and the time the girl was permitted to return, thus resulting in her falling further behind classmates and raising her chances of failure and dropout (Howard, 1970). As the public has become increasingly aware of the school-age parenthood problem, they have begun to recognize that these parents could be high risk for numerous other problems and that they have been very poorly served.

AN OVERVIEW OF PROGRAMS FOR ADOLESCENT PARENTS

The unwillingness of the educational system to respond to the school-age pregnant girl as well as concern for the rising number of pregnancies to unwed girls caused many professionals and nonprofessionals to seek alternatives. They recognized that the educational system, had it been sympathetic, was not equipped to effectively meet the special health and social support needs of this population. To combat the growing problem and to provide special services, comprehensive programs were developed in the 60's outside of the school system (Boykin, 1968; Gordis et al., 1968; Howard, 1968; Iungerich, 1967; Sarrel, 1967). The programs

were staffed by multi-disciplinary teams to meet the specialized needs of the girls.

The programs offered academic, health, sex, family and vocational education as well as medical services. When medical services could not be provided at the program site, services were contracted with a local hospital or clinic. The major focus of the comprehensive programs was educational. It was felt that an academic education would promote regular school return as well as provide health and sex education that would curtail subsequent pregnancies and facilitate well-being in the girls (Baizerman, 1971). Classes were small, often allowing for individual instruction, and generally held away from campus. Professionals felt that services away from the mainstream lessened the pregnant girl's embarrassment and curtailed humiliating remarks from classmates.

The first of these programs was the Webster School which was established in 1962 by the Children's Bureau in Washington, D.C. It included a multi-disciplinary, team approach to education, medical, and social services (Klerman and Jekel, 1973). Many other programs followed, most of which sought to delay subsequent pregnancies, keep the young women in school, decrease health risks for mother and child, and help the young women choose meaningful career directions. A short review of a selection of the programs will illustrate the various ways society attempted to meet the challenging problem of teenage pregnancy.

The Continuing Education for Girls in Detroit was established in 1966. This program served 250 girls each year with emphasis on girls under sixteen. In a simulated school setting, the pro-

gram provided educational, medical, psychological and social services (Boykin, 1968). The interesting aspect of this program is that it provided services to the parents of the pregnant girl and also to the putative father (Howard, 1968).

Also providing academic, medical, psychological and social services within a simulated school setting is the Educational and Medical Program for School Age Girls (Ed-Med) (Iungerich, 1967). Established in Pittsburg in 1965, the program grew out of the Urban League's concern for the school-age, pregnant girl. The program was provided in conjunction with the Pittsburg Board of Public Education. Selection criteria was based on the girl's desire to attend the program, her parent's support, and a doctor's certification of her pregnancy (Howard, 1968).

Many other comprehensive programs were hospital based (Gordis et al., 1968; Sarrel, 1968). The Adolescent Comprehensive Clinic in Cincinnati, characteristic of many hospital-based programs, provided complete adolescent care including prenatal and birth control information and services. The multi-disciplinary clinic focused on easily available medical care for this target group and on open, trusting relationships with individual physicians (Raub and Burket, 1971).

The Young Mothers Education Development (YMED) program was a comprehensive program with a medical focus established in Syracuse in 1966. Included in this program were comprehensive medical, educational, social, day care, and psychological services. All school-age girls were accepted into the program regardless of their medical, educational, or social problems. The intent of the pro-

gram was to abandon the clinic concept of obstetrical care and substitute this with a meaningful relationship between the young woman's physician and herself (Osofsky, 1968).

Another comprehensive adolescent maternity program at San Francisco General Hospital included an innovative program element: vocational education. Classes were held in a mock business setting, and community business people visited the program to tell about their firms. The program, in addition, offered parent training, general guidance, high school completion, and prenatal care and counseling. The goals were to provide employment skills, to help young women develop goals, pride, and self-esteem, and to break the school dropout, additional pregnancy, and Welfare cycle (Goldstein, Zalar, Grady and Smith, 1973).

The Teen Obstetrical Clinic at the University of Pennsylvania Hospital used teams of nurses, pediatricians, caseworkers, groupworkers, school counselors, and medical students to provide complete services. Weekly discussion groups, frequent prenatal visits and personalized services were emphasized (Dickens, Hartshorne, Garcia, Tomar and Wright, 1973).

The cooperation of a county health department is illustrated by a program developed in the Los Angeles City Unified School Districts. Public education was the focus of the program. The objective was a continuing education for the young women which was assumed to be more helpful in providing for their future health than anything that could be done in clinics or by home visits. The program's assumption was that an educated population was a healthier population (Lyons, 1968).

A community action approach was used by Project Teen Aid in New York City. Several unique aspects were included in this comprehensive program along with home visits by nurses from the Visiting Nurses Association, a community resource coordinator, and a goal-oriented approach. The latter aspect was described as,

> "designed to participate with pregnant teenagers in developing realistic goals based upon appropriate assessment of her potential, and also a knowledge of available community resources" (McMurray, 1968, p. 1852).

Another approach used to help the pregnant teenage girl that was prevalent in the sixties was group counseling (Barclay, 1969; Barnard, 1970; Danforth, 1971; Day, 1967; Klaus et al., 1973; Lau, 1971). Utilized in comprehensive programs or as the sole means of service, the group approach was seen as effective for "disseminating information, relieving the anxieties of the women, airing their personal problems, and helping them to make realistic plans for the future" (Baizerman et al., 1971, p. 8).

This sample of programs indicates the variety of solutions attempted to address this very complex problem. They were the first real attempts to deal with school-age pregnancy but, unfortunately, they have limitations which prevent their potential effectiveness (Baizerman et al., 1971; Howard, 1968). Baizerman and his associates (1971, p. 8) point out that, "One is the limitation on the number of women served in relation to the total population of pregnant teenagers." There are just not enough programs to deal with the situation. Secondly, the length of service is limiting. Most programs cease the provision of service once the girl reenters regular school. At a time when she is greatly in need of support,

the services are no longer available. The third and perhaps most important limitation was that most programs were prohibited by law from disseminating birth control information or devices, thus making efforts to reduce subsequent pregnancies futile.

The Planned Parenthood Federation of America also reported, in 1976, that services for pregnant adolescents were very inadequate and that much of the target population is not being served. Although programs numbered 350 by 1974, many were offering very limited services and 75 percent of the comprehensive programs offered no birth control services. The Guttmacher Institute (1976) found that 80 percent of day care centers do not care for children under age 2 which presents another barrier to the adolescent mother who wishes to continue in school. Lack of day care often means forced interruption of school or financial dependence from which many girls find it hard to extricate themselves.

Why have we failed the pregnant adolescent girl? Why has she been so difficult to serve? Perhaps some of the reasons lie in problems of the whole society. The following section will explore some of the issues that may be involved.

SOCIAL ISSUES

Attitudes Toward Adolescent Sexuality

One of the crucial issues to be addressed in relation to adolescent pregnancy is this society's attitude about adolescent sexuality. The media promotes sexuality, then condemns the results (Klerman et al., 1973). With this lack of acceptance of changing sexual mores, society has really not sanctioned adequate sex educa-

tion and readily available birth control (Plionis, 1975). Even when birth control is available, society's negative view of adolescent sexual intercourse has influenced teens not to use it. Prudence Rains (1971, p. 32) states in Becoming an Unwed Mother,

> "A girl who, in some measure, still adheres to a standard that excludes sexual intercourse may prefer the risk of possible pregnancy to the more probable risk of loss of reputation."

In her book, Adolescent Sexuality in a Changing American Society, Chilman (1978) has reviewed the literature pertaining to the use of contraceptives by teenagers. The following relies heavily on her work. Chilman writes that by 1973 premarital intercourse was occurring at younger ages than in the past, with about one-fourth of the white males and females apparently becoming sexually experienced by age 15 or 16. Ninety percent of black males and about 50 percent of black females were sexually experienced by age 15 or 16 (Conger, 1973; Chilman, 1978). Studies reveal that a disturbingly high percentage of these young people were not using contraceptives.

> "Only about 50 percent of sexually active females studied between 1968 and 1974 said they used any form of contraceptive at their first intercourse. About half of those of high school age reportedly have never used any form of birth control. Only half of the sexually active college age women say they use contraceptives consistently, but this is true for only 20 percent of those age 19 or younger (31 percent of the white and 17 percent of the blacks)" (Chilman, 1978, p. 155).

According to reports before 1975, only about one-fourth of the sexually active young people under age 18 said that they used the pill. Between 25 to 50 percent of high school age youth report that they use the condom at least occasionally. 89 percent

of black males and 69 percent of white males in high school said they had used nothing at least once (Chilman, 1978; Conger, 1973).

One study found that 40 to 60 percent of the sexually active single females, both black and white, depend on the male method of contraception (Zelnik and Kantner, 1973). Chilman (1978, p. 156) states that,

> "Because the majority of adolescent males seem to be markedly inconsistent and perhaps unconcerned about contraceptive use, there seems to be a central problem with respect to their attitudes and behaviors and reliance of so many single adolescent girls on the contraceptive vigilance of boys."

Some of the factors associated with contraception use are the following: contraceptive use increases with age; girls, both black and white whose fathers have graduated from college, are more likely to use contraceptives; lower-income white girls are less likely to use more effective methods than higher-income whites (Chilman, 1978). According to Chilman (1979), studies by Stack in 1974, Ladner in 1971, Rainwater in 1970 and Rubin in 1976 show that adolescents who do not use contraceptives hold fatalistic attitudes, have strong feelings of powerlessness or alienation and feel that life is controlled by external events. It also appears that traditional attitudes toward the female role as well as risk-taking attitudes are associated with poor contraceptive use (Chilman, 1978).

Warren Miller noted in his study of adolescent use of contraceptives that anxiety in the females he studied played a part in their use of contraceptives. If her pregnancy anxiety was too low, she did not use contraceptives; but if her combined anxieties about

pregnancy, her sexuality, and contraceptives were too high, she would be overwhelmed and unable to take effective action. Miller observed that self-esteem, future orientation, and ability to control impulses were of great importance to contraceptive use (Chilman, 1978).

The role of cognitive development has been suggested as a factor in the adolescent's failure to use contraceptives. The cognitively immature adolescent may find it hard to see herself as becoming sexually adult. She may feel that she is immune to pregnancy or she may have little ability to foresee possible consequences. High pleasure seeking of early adolescence has also been associated with nonuse of contraceptives. Failure to accept one's own sexuality results in nonuse of contraceptive methods. Chilman believes that,

> "Because most women have been socialized to protect themselves against the sexuality of males, to preserve their own virginity until marriage, and to fear premarital pregnancy, they may have problems facing the fact that they are violating internalized norms and are taking pregnancy risks" (Chilman, 1978, p. 166).

Chilman's (1978) study of the research indicates that adolescents who are sexually active gradually move toward more effective contraceptive use as they gain a more realistic awareness of their behavior, the possible consequences, and of the possible contraceptive methods available.

In interviewing 500 young women applicants for abortion who had been "contraceptive risk-takers," Luker found that there are rational reasons in a personal-emotional sense for their decision to not use contraceptives or to use ineffective ones. According to

Luker, the women used a cost/benefit approach in their decision to use or not use contraceptives. The costs to the woman, that Luker identified, are summarized as the following: (1) Acknowledging that she is actually engaging in sexual intercourse. (2) Planning ahead that she is going to have sexual intercourse by preparing for it whether she has a continuing, committed relationship or not. This kind of initiative makes the woman feel uncertain about her femininity. (3) Planning the continuous use of contraceptives, even when her sex life is irregular or if she presently has no lover or partner, makes the woman feel promiscuous (Chilman, 1978).

Other dangers for the woman are: (4) When unexpected passion leads an unprepared couple to intercourse there is often no readily available source for purchasing contraceptives. If the female does anticipate intercourse she will expose herself as sexually active to those from whom she purchases the contraceptives; for instance, the druggist. (5) Many women perceive men as expecting or demanding intercourse and because of learned obsequiousness to men will go along whether prepared or not. (6) Birth control methods sometimes have physical side effects that women justifiably fear. (7) The fear of infertility seems to drive some women to prove that they can get pregnant (Chilman, 1978).

The benefits of pregnancy that Luker identified are listed by Chilman (1978, p. 169):

> "1. It fulfills woman's traditional role. 2. It provides a child to love. 3. It is a proof of fertility. 4. It tests a man's commitment; it may encourage his desire for marriage or bolster a failing marriage. 5. It may please a husband or lover. 6. It is an attention-getting device from parents or others. 7. Pregnancy can

> be a 'cry for help' or a risk-taking thrill (ideas of these kinds were relatively rare)."

Investigative studies of adolescent sexuality that Chilman reviewed seem to show that knowledge of contraceptive methods apparently often either eludes many adolescents, or it is unavailable to them. Recent surveys show that sex education is offered in about one-third of the nation's public schools, but details about contraception are rarely mentioned. Even those boys and girls who have had sex education classes are often unable to incorporate their knowledge with their behavior. In one study of the effects of sex education on boys, the authors found that the boys had gained a slight increase in knowledge, but their self-reported contraceptive measures did not change (Chilman, 1978).

It is Chilman's conclusion (1978) that traditional sex education programs are not enough to make an impact on the contraceptive behaviors of teenagers but rather than discard them, other methods that effectively take into account the total life situation, stage of development, and related lifestyles of young people need to be explored and incorporated.

Schinke (1978) agrees that availability of contraceptives alone is not enough. He proposes a solution of providing interpersonal skills training in conjunction with providing contraceptives. He contends that this would help to develop responsible adult roles including sexual behavior. The intent is to teach adolescents to refuse unreasonable requests; and, also not make unreasonable requests. Small group assertiveness training and role play work with positive reinforcement from peers and group

leaders was reported by Schinke as improving contraceptive use. This seems to substantiate the view that in this culture attitudes about youth's sexuality work against their being able to make clear and responsible choices.

There has been much speculation about the characteristics of the young people who engage in premarital intercourse. Conger (1973) writes that there is increasing evidence that sex, age, socioeconomic and educational level, race, religion, and even geographic area appear to be related to sexual attitudes, values and behaviors. Chilman (1978, p. 136) states that,

> "positive attitudes toward education, higher levels of educational achievement, and clear educational goals appear to make premarital intercourse less likely for both white and black females."

Chilman (1978) sees the lower likelihood of premarital sex and higher educational achievement closely linked to "interacting socioeconomic, social, psychological and situational variables." In other words, the girl who accelerates in school is most likely to come from a

> "family background of higher socioeconomic status; to value achievement; to be more rational, controlled, and conforming in orientation; to be oriented to work rather than play; to operate on a higher level of cognitive development; and to be able to foresee and plan for the future" (Chilman, 1978, p. 136).

Thus, it is apparent that there are many factors that contribute to the poor utilization of contraceptives by adolescents. If society is to effectively deal with the problem of early premarital pregnancy, we must be prepared to use an approach that takes into account all the factors involved.

Some Variables Linked to Premarital Teenage Pregnancy

Historically, giving birth to an illegitimate child in most countries meant the mother and child would be outcasts from society, often disowned by family and barred from a respectable marriage and employment. The child was labeled a "bastard" and was often deprived of financial support and an education. "Better" families kept the pregnancy in utmost secrecy, sent the girl off to deliver secretly and placed the child out for adoption. With such severe stigma attached to illegitimacy, most girls avoided pregnancy until they were able to marry. The girls who did become pregnant in such a cultural climate came to be seen as having special psychological problems and needing professional guidance (Chilman, 1978).

In recent years, norms that proscribed premarital sex for women and condemned the unmarried mother have faded.

> "Illegitimacy no longer presents the critical problem it once did. This is because of such factors as less emphasis on inheritance of land and capital by family members, more jobs for women, the push for equal rights of women, Welfare programs for mothers and children, and more permissive attitudes toward sexual behavior" (Chilman, 1978, p. 206).

Even though this country is experiencing enormous changes in sexual attitudes and condemnation of the unmarried mother has diminished, human service professionals still see her as presenting complex psychological and social problems (Chilman, 1979). The following examines ways the professionals view the problem.

A psychological theory widely accepted by professionals in social work and other helping disciplines in the 50's and early 60's that attempted to explain unwed pregnancy was the single

causation theory. The theory held that becoming an "unwed mother was a purposeful act symptomatic of emotional problems" (Eddinger and Forbush, 1977). Prevalence of this theory heavily influenced all programs and services rendered to the pregnant unwed adolescent (Bonan, 1963; Goldsmith, 1957; Friedman, 1966; Trout, 1956). Bonan (1963, p. 323) states,

> "that to be helpful, the social worker must be attuned to the nature of the problem. He must recognize that the girl's situation is not an accident; in her acting out she is trying to escape from serious internal problems."

Professionals linked these internal problems to a faulty mother-daughter relationship. They believed that the faulty relationship led to a narcissistic adolescent or young woman who unconsciously used pregnancy as a way to deal with her unstable emotional character (Bonan, 1963). Other professionals link the emotional difficulties of the pregnant, unwed girl to the mother's inability to provide a constructive, maturing relationship (Goldsmith, 1957; Trout, 1956). These professionals viewed helping disciplines as providing a corrective mother model setting standards and morals within the context of the service rendered.

Finally, some professionals believed the unwed, pregnant girl's emotional difficulties were linked to emancipation. "Her illegitimate pregnancy is the result of an attempt to solve certain emotional conflicts, and often her central problem is one of emancipation from her parents" (Goldsmith, 1957, p. 69). In essence, the predominant professional position was to view illegitimate pregnancy as an indication of underlying emotional problems and thus requiring psychiatric counseling as the treatment modality.

With the advent of the 60's, professionals began to challenge the universality of the single causation theory (Bernstein, 1960; Walters, 1965; Wessel, 1968). Recognizing that in some instances illegitimate pregnancy may be symptomatic of underlying emotional difficulties, they believed the percentage of such cases were relatively low. These professionals supported a broader base of causation.

In explaining unwed, adolescent pregnancies in the black population, professionals did not apply the single causation theory but viewed it from a sociological perspective (Garland, 1966; Plionis, 1975; Shlackman, 1966). Garland (1966, p. 84) cites Perlman who states,

> "in examining social work treatment of the unwed mother it becomes clear that there are two different theories: the dominant theory is the psychoanalytic approach applied largely to the white unwed mother; the other, sociological theory, is applied chiefly to the Negro mother."

The sociological theory explained that black unwed pregnancy was a culturally acceptable and inevitable way of life. Furthermore, professionals rationalized the lack of services to this population by assuming that the strong matriarchal family, characteristic of black culture, would care for the mother and her illegitimate child. Consequently, while the white unwed mother received psychoanalytic counseling in maternity homes, the black unwed mother existed in a service vacuum (Garland, 1966).

During the late 60's and early 70's, professionals began to question the validity of the sociological explanation of black unwed pregnancy (Billingsly, 1970; Furstenburg, 1970; Garland, 1966; Plionis, 1975; Shlackman, 1966). Between 1966 and 1968, Fursten-

burg (1970) conducted interviews of all unwed mothers entering Sinai Hospital in Baltimore for prenatal care. 96 percent of these unwed mothers were black. The study findings did not support the sociological theory. The majority of the black pregnant girls and their mothers were both unhappy about the girl's pregnancy. Another significant finding was that 90 percent of the pregnant black girls stated that they did not have sufficient birth control knowledge and that had contraception been available, two-thirds would have used it. Furstenburg's study was the first attempt to dispel the black/white dicotomous theories and strive for a broader spectrum of causation for the pregnant teenager. This was the beginning of a trend to distinguish racism as a major causative factor in black illegitimate pregnancies.

Some professionals have identified ambiguity of sexual norms as a causative factor in unwed pregnancy (Bernstein, 1960; Chilman, 1978; Walters, 1965; Wessel, 1968). Bernstein (1960, p. 23) states, "the professed code of behavior has not kept pace with the changing practices and the ideal of chastity and marriage continues to be cherished along with other cultural fictions." Others see the socialization for female roles as having a strong effect on the process that leads to unwed teenage pregnancy. Many women are still being socialized to accept pregnancy as the only viable option open to them (Chilman, 1978).

Chilman (1978) cites additional reasons for rising illegitimacy. A cultural factor to be considered is the recent marked decrease in the rates of early marriage. Growing urbanization is another factor. Urbanization brings about, "personal and familial

disorganization because old norms and values no longer readily apply, social controls are harder to enforce, life is more anonymous and temptations increase" (Chilman, 1978, p. 207).

Industrialization has been recognized as contributing to increasing illegitimacy rates. Industrialization undermines the necessity of the family as an economic unit and provides women with the opportunity to be self-sufficient. Another factor is more careful record keeping by states since the passage of the Social Security Act of 1935 which may have contributed to some of the observed rise in illegitimacy rates. Welfare programs are often seen as a causal link to illegitimacy because almost half of the women who receive Welfare aid are single. Numerous studies have analyzed large bodies of data from many countries and do not find the availability of Welfare benefits increases illegitimacy rates (Chilman, 1978).

Some researchers have cited unemployment as a cause of teenage illegitimacy. They claim that high unemployment rates of youth make marriage near impossible for some pregnant couples. Unemployment leads to poverty which has been linked to rising illegitimacy rates. Chilman writes that research is not clear on this matter, but that it does indicate that girls whose parents have more than a high school education are more likely to consistently use contraceptives, to marry to legitimate a pregnancy, or to choose an abortion if premaritally pregnant (Chilman, 1978).

Chilman (1978) has hypothesized that "culture lag" is an important contributing factor to increasing teenage illegitimate pregnancy. Culture lag is evident when contraceptive service programs

for teenagers do not keep pace with changes in sex attitudes and behaviors of the majority of the nation's young people. Chilman points out that although changes in public policy provided free or low cost federally funded family planning services in 1966, conservative groups and the Catholic Church made it impossible for these services to reach adolescents. Lawmakers, cultural leaders, and parents show much concern about the effect of premarital intercourse on young teenagers and fear the availability of contraceptives will increase this behavior. Additionally, the adolescent girl's internalized traditional norms often make it difficult for her to use family planning services or to discuss her need for contraceptives or abortion with the adults who can help. Conger (1973) has observed that the entire situation has created conflicts, confusion and anxiety in both parents and teenagers.

The research attempting to identify causes for illegitimacy among adolescents seems to indicate that there are a host of social, psychological, and economic variables at the root of the problem. In planning services for the unmarried, pregnant adolescent girl, all of these factors need to be considered. Chilman (1979, p. 496) says, "Genuine efforts to prevent adolescent childbearing and its alleged consequences...must change the social and economic situations that are the primary cause of these problems."

Racial Prejudice

In a country where racial discrimination is a fact of life most social problems have a racial element, and adolescent pregnancy is no exception. Many of the participants in the programs

previously described were from minority groups, and indeed minorities are the target group most in need of services. Public health statistics indicate that in the U.S. black infants die at twice the rate of whites, and black mothers die at four times the rate of white mothers. With teenage mothers already considered in the high risk group medically, black adolescents and their infants are especially vulnerable. Added to this medical risk are the social realities that 40 percent of nonwhite households live below the poverty level and attain less schooling and employment (Dickens et al., 1973). Racial prejudice also combines with the "deviance" label assigned adolescent pregnancy to make life situations even worse for minority adolescent parents. In addition, the alternatives are limited for young black women, since it is more difficult to adopt black infants, and the idea of being sent away to have the child and releasing it for adoption is either not possible or not culturally accepted (Klerman et al., 1973). Therefore, racial prejudice is another societal problem which further complicates efforts to intervene with adolescent parents.

Society's Attitudes Toward the Poor

Closely related to the racial issue is the problem of poverty as it relates to adolescent pregnancy. Matthews states that there are,

> "inequities in social welfare policies which confront us daily, and these have certain implications for establishing truly effective services for pregnant unwed teenagers--for unwed mothers in general" (McMurray, 1973).

She lists lack of adequate housing, day care, availability of continuing educational or vocational training, adequate medical ser-

vices, and adequate Welfare benefits as inequities which hamper service delivery. If society and individual communities are not supportive, an isolated program can't work miracles.

A reality is that many pregnant teens get pulled into what Walters calls the syndrome of failure: "Failure to fulfill adolescent function, remain in school, limit family size, establish stable families, be self-supporting, and have healthy infants" (Webb et al., 1973, p. 511). For some, this pattern leads to becoming a Welfare recipient with all the stigma and inequities which that involves. Adolescent pregnancy is not an isolated problem, but is closely connected with many social problems this country faces. Without a different attitude toward poverty, it is difficult to intervene with many social problems, including adolescent pregnancy.

Lack of a Meaningful Role for Youth

Another issue which confronts those working with adolescents in both preventive work and work with pregnant teens, is this country's lack of a meaningful role for youth. School is "the role" and perhaps for many it is an unsatisfying one. There are few types of satisfying employment, and for young women the roles are even more constricting. Klerman (1975) thinks that these cultural inadequacies may contribute to the high incidence of teenage pregnancies. Young women may seek to reach the pinnacle of wife and motherhood as soon as possible because alternative roles and sources of positive self-identity are few.

One study addressed the school role of youth and how it may be inadequate. The researchers found that increased risk of preg-

nancy is associated with both below average, but also surprisingly with above average grade attainment (Hansen and Whitaker, 1978). Perhaps this speaks to our country's ability to satisfy the needs of middle achieving youth, and an inability to accommodate anyone "different."

All these societal issues make it difficult to develop programs which address all aspects of this complex problem. This society's attitudes about teenage sexuality and pregnancy, race, poverty, and youth's role in general, hinder program efforts to help teen parents. Programs can't be expected to solve these larger problems; the question then is how much they can accomplish given these limitations.

Program Issues

Within this climate, programs have to tackle just where, how, and to what degree they will intervene. Typical decisions include: Should pregnant teens be separated from their peers? Does this separation tend to isolate them, push the problem out of society's view, and create barriers to re-entering the community? How long should the intervention last? Is regular school best for some and special school best for others? (Foltz, Klerman and Jekel, 1972). Should fathers be involved? Klerman (1975) thinks this might be a detriment, as it often leads to early marriage, additional pregnancies, and subsequent divorce. Should the focus be on initial pregnancy prevention or subsequent pregnancy prevention? Should abortion be an alternative offered? (Plionis, 1975). Should programs admit only highly motivated young women? How should the goals of

adequate parenting, continuation of education, and employment be balanced? These are difficult issues to confront.

EVALUATION

The problem of adolescent pregnancy is obviously a complex and far-reaching one. Programs must constantly evaluate, grow, and change in order to meet the needs of this high risk target group. In addition, the programs need to be aware of results because, as Foltz and associates (1972, p. 618) state, "If society is going to continue to finance special programs, it should know what type is most effective." They go on to state, however, that society must clarify its goals and set priorities before programs can prove effectiveness. However, it seems necessary for these two processes to develop simultaneously; evaluation can't be set aside until society has faced all the issues and clearly defined goals. Diverse programs to meet diverse needs seems the only answer. Knowing what works, within the context of the social realities previously discussed, is crucial even though difficult. A review of some evaluative studies not only shows mixed results, but reveals the complexities in the task of evaluation and just how crucial it is to know both short-term and long-term effects.

As mentioned earlier, the Webster School was the first attempt to deal with the educational, medical, and social service needs of pregnant, school-age girls. In 1967, under the auspices of the Washington, D.C., Children's Bureau, an evaluation of this program was undertaken. This evaluation is of great importance, as the school was the front-runner of all comprehensive programs for

this population. Evaluation was based on three variables: the ability of Webster to promote regular school reentry and maintain continuance until graduation; the ability of the program to improve the outcome of pregnancy; and its ability to reduce subsequent pregnancies, especially out-of-wedlock pregnancies. The study group was composed of 136 students, enrolled during the school's second year of operation (1964-1965). The comparison group consisted of 136 girls referred to Webster but not accepted and was matched to the study group by age and race. All participants, except four, were black. Furthermore, information from all Webster School students as well as information on all pregnant, black, school-age girls residing in the District of Columbia was utilized within the evaluation (Howard, 1968).

The outcome of the evaluation presented success as well as failure. The evaluation showed that the Webster School Program was successful in promoting school return. At the time of the study, "over four-fifths of the girls who attended Webster reentered regular school" (Howard, 1968, p. 43). However, those selected for the program were determined strongly motivated to continue in school, as well as having highly motivated parental or guardian supports. The program was unsuccessful in maintaining regular school continuance until graduation. "By June, over one-third of those who returned had dropped out" (Howard, 1968, p. 44). Reasons stated for dropping out were subsequent pregnancies, poor attendance, baby care, work, and marriage. The program was fairly successful in improving the outcome of pregnancy. Although the study was unable to show a statistically significant improvement,

"the Webster girls and their infants showed some measure of improvement" (Howard, 1968, p. 57). Furthermore, when all Webster students were compared to all pregnant, black, school-aged girls in the District of Columbia, the former showed significant improvement in the outcome of pregnancy. The study also showed that the youngest mothers, regardless of program participation, were the highest medical risks. Finally, the evaluation showed the program was unable to reduce subsequent pregnancies. "The present study showed that nearly half of all girls in that group had second babies within 30 months of the first child" (Howard, 1968, p. 56). The majority of these subsequent pregnancies were out-of-wedlock. However, birth control information and devices were not permitted on school premises and, therefore, the method utilized to control subsequent births was to encourage abstention. In conclusion, the author claims relative success for the program, yet emphasizes that Webster School students are unrepresentative of the total pregnant student population. "The point is made only to emphasize that what is learned from this project's experience should not be generalized to all pregnant school girls in the District unless further study is made" (Howard, 1968, p. 26).

Although generalizations cannot be made from the findings of this study to the total school-age population, the Webster School evaluation is important, as it raised several considerations which are valuable for all programs of this nature to address. If the program is concerned with behavioral changes, the duration of the program is a valuable consideration. The Webster School Program

had a duration of approximately 18 weeks, following which the young girl was to reenter regular school. The author questions, "How much change could realistically be expected to result from that length of schooling and other services" (Howard, 1968, p. 56)?

Secondly, the author raises the consideration of providing services during the first year of regular school reentry. Webster School services ceased once the young mother returned to regular school. Reviewing the reasons stated for failure to remain in regular school until graduation, the author states that supportive services from the school may have curtailed the drop-out incidence. Finally, the ability to prevent subsequent pregnancy may be successful if the program provides birth control information and devices. The Webster School was legally unable to implement birth control and thus utilized the unrealistic approach of discouraging sexual relations. The program was unable to prevent subsequent pregnancies.

One of the classic evaluations of programs for adolescent parents was done by Klerman and Jekel in Connecticut--over the time period of September, 1967 to June, 1969. This is an especially important study because two programs were compared with a control group who received only obstetrical care and were not allowed to attend school past their fourth month of pregnancy. The first group from the Young Mothers Program in New Haven all attended the McCabe Center school, were given medical services in a hospital clinic with personally assigned nurses and midwives, and the assistance of social workers, visiting nurses, counselors, group sessions, and other services. The second group participated in the

Inter-Agency Services Program connected with the Poverty Program in Hartford. Social casework services were provided through the special school. Obstetrical services were from various clinics and private physicians (Klerman et al., 1973).

The outcome variables included the health of the mother and infant, educational status, subsequent pregnancy, employment status, and financial support. The authors point out various limitations in the study, such as incomplete records, somewhat unequal groups, and interviewer contamination. The results are also colored by who was accepted into a program; for example, a program which includes only "good risk" girls will be more successful, whereas the control group included all types of subjects. Nevertheless, the results can provide some general conclusions. The two programs were equally effective in fulfilling some short-term goals: the infants were significantly more healthy at birth; the mothers delayed pregnancy significantly longer than the comparison group; and the two programs were largely successful in keeping the girls in school who had already been there. However, the two programs were unsuccessful in fulfilling long-term goals: the girls made little economic progress and dropped out of school; subsequent births were high in prematurity and mortality; and the young women experienced many social problems, such as suicide attempts, divorce, domestic violence, and child abuse (Klerman and Jekel, 1973).

Several major conclusions Klerman and Jekel (1973) offer are that programs for adolescent parents need to last longer so that the impact is more permanent than crisis intervention, that the two

special but different programs produced relatively similar results, and that the young women served are typical of all young women and have a right to educational and medical services. They suggest admitting all young women, using an unconventional curriculum, and having a reality oriented program responsive to the needs of those served.

Another follow-up study indicates similar short-term success. The Continuation School for Pregnant Girls, a comprehensive program offered under Title I of ESEA and Section LV of the 1966 Michigan State School Aid Act, reported better birth weight of infants of those girls who remained in school an average of four months. In contrast, a group who were not in school long enough to benefit from nutrition and prenatal classes had babies under 5 pounds and evidenced a high incidence of obstetrical complications and bladder infections. A follow-up of 234 young women showed only 30 percent had graduated from high school, although 150 of the 234 planned to continue and graduate (Harrison, 1972). It would be interesting to know what barriers to completing school these young women were experiencing. The results seem to agree with Klerman and Jekel's (1973) conclusion that short-term goals are being met, but programs don't last long enough to meet long-term goals.

A possible solution to the lack of fulfillment of long-term goals is presented by Dickens and team (1973) in a report of an evaluation study. One hundred pregnant teens were studied at the University of Pennsylvania Hospital (50 from the prenatal clinic as the control group and 50 from the Teen Obstetrical Clinic which used a personalized team approach and weekly discussion groups).

The program group had fewer repeat pregnancies after a short time, a slightly higher percentage attended classes, accepted contraceptives, and returned to school. Basically the two groups showed few outcome differences. Of particular concern to the program was that a two and one-half year follow-up showed both groups to have 42 percent repeat pregnancies. The recommendation for preventive services was intensive public education, especially for sisters and parents of pregnant girls and their friends in the form of neighborhood discussion groups. This study supports the analysis that adolescent pregnancy is a complex problem interwoven with many other social problems.

An important follow-up study of medical outcomes is reported in the winter, 1978, journal, Adolescence. Service in three different health settings were compared: 1. The Rochester Adolescent Maternity Project (RAMP); 2. an obstetrical clinic; and 3. a neighborhood health center. The results show that the RAMP group experienced a lower incidence of anemia and pre-eclampsia, a much higher percentage using contraceptives than at the clinic, although similar to the neighborhood center, a lower repeat pregnancy rate than the other two settings, and a much higher rate of keeping health appointments one year after birth than the clinic (Tatelbaum, Kash, Adams, McArarney, Roghmann, Coulter, Charney and Plume, 1978). Further follow-up would be necessary to insure that long-term health goals were met, although, clearly, short-term health goals were achieved by this program.

A study of the Children's Hospital Adolescent Maternity Center with school support from the San Francisco school district

compared a school and non-school group on health outcome variables. There were no significant health differences in the two groups, except that the school group experienced shorter labors and more consistent prenatal care. The program, however, did note that health problems were diminished by the comprehensive program, and that the center was serving the higher risk group of younger, black, primiparous, and unmarried women (Webb et al., 1972). This lack of clear help in health areas through remaining in school may reflect an earlier observation by Klerman and Jekel (1973) that "poor risk" young women, which this program is serving, may make the results look bad. This should not mean that a program be discontinued, for it is this high risk group which needs the help most.

An evaluation of comprehensive services of Project Team Aid described earlier showed very positive results. The program is credited for a decrease in the perinatal mortality rate from 30 per 10,000 to 27.95 per 10,000; there were no second unwed pregnancies after less than two years; 62 percent of the young women returned to regular school; and 21 percent had accepted referrals for vocational training (McMurray, 1968). These seem to be impressive results for this goal-oriented program.

Other positive outcomes are reported by Schinke (1978); not for a program but for two elements which could be incorporated into a program. Research by this author and his colleagues on training school-age parents in job interviewing shows the positive impact of brief, intense instruction on specific skills and on "hireability" ratings assigned by professional personnel specialists. The same researchers state that,

> "empirical findings from research suggest that interpersonal skills training combined with accurate contraception information has great potential in the prevention of unwanted teenage pregnancy" (Schinke, 1978, p. 410).

This interpersonal skills training is described more fully in a previous section on attitudes toward adolescent sexuality. It is with research such as this that specific preventive and interventive techniques can penetrate the complexities of the problem and delineate just what in the program helps and what seems to have no effect.

A further evaluation, focusing on health variables, was conducted at the Edgar Allen Poe School in Baltimore (Stine et al., 1970). The evaluation reports "the differences in morbidity and mortality in infants born to mothers attending the special school with infants born to a control group" (Baizerman et al., 1971, p. 14). The study group was composed of 224 young mothers enrolled in the school between September, 1967 and December, 1968. The control group was compiled by locating the births of infants during the designated time frame and then matching the young mothers to the study group by variables of age, race, and sex and birth order of infants. Comparing these two groups, several findings were obtained: few infants weighing less than 2501 gms were delivered to mothers in the school; a small proportion of infants born to mothers in the school had gestation periods of less than 37 weeks; and mortality rate was lower among the infants of the school mothers. Upon completion of the evaluation, the authors concluded that the control group experienced a higher incidence of infant morbidity and mortality and that it was statistically significant.

However, the validity of this finding has been questioned due to the failure of the evaluation to recognize casual variables beyond program participation.

A 1973 follow-up study of interest examined the Young Mothers Educational Development (YMED) in Syracuse; a program emphasizing an interdisciplinary approach to low-income, pregnant adolescents (75 percent were on full Welfare). In five and one-half years 450 girls delivered within the program. The facility, located near a hospital to encourage adequate medical care, housed all services (except hospital) under one roof, including an infant nursery. The program was intensive and personalized, with individualized planning as a basic function. Reproduction and contraception information were stressed (Osofsky et al., 1973).

The results indicated educational success, since the majority of the girls met educational requirements and beyond. Although the incidence of major complications were reduced markedly, the indicence of anemia and small-for-dates infants did not reach optimal levels according to the researchers. By one year of age, 62 percent of the babies were still below the 50th percentile in weight and height. Some other complications the program did not greatly reduce were bacilluria, mild toxemia and gonorrhea (Osofsky et al., 1973).

There is evidence that unwanted repeated pregnancies of the participants had been reduced by 75 percent. A follow-up study of girls enrolled during a two year period showed that only 13 percent were at home with infant--without meaningful education, work, or marriage--and receiving Welfare assistance (Osofsky et al., 1973).

It appears from the results of this study that girls do benefit from services offered but that the serious problem of low birth weight infants has yet to be solved.

Another evaluation study of a comprehensive program for unwed mothers administered by the Florence Crittendon Association of America in Chicago was conducted between 1966 and 1977. The program included special school for pregnant teens, health-related services, and social and supportive services. Among the hypotheses tested were that a greater number of those clients who receive comprehensive services will show positive change than those who do not receive services; client functioning will be enhanced by services; medical risks will be decreased by services; and unwed mothers in the program will be more likely to remain in school. There was difficulty in obtaining a control group, so that the results can only speak for whether those served were helped (Bedger, 1980).

Much emphasis in this study was placed on behavior change as related to attitude change which occurred. Rating scales utilized at intake and termination measured social service potential, which included verbal responsiveness, self-awareness and ability to relate; social functioning, which included relationships with family and putative father, plan for the baby, and personal goals; and environmental stress. Overall, a significant positive change in behavior of subjects was observed. It was found that 55 percent of all cases were rated more positive in social functioning and that 69 percent of those using major services more than one month changed their functioning level in a positive direction. Some

specific results included: communication patterns in families improved; role relationships with fathers improved; role relationships with mothers got slightly worse; plans for the baby were considered positive for 70 percent at case closing; and environmental stress was lessened in 12 percent of the cases. Data on pregnancy outcome and school continuation also verified a positive relationship between care and outcome (Bedger, 1980).

This study also included an analysis of therapeutic groups provided in the social services area and nursing area. An analysis system modeled after Bales showed that the goals for the nursing groups were much more specific and, therefore, more measureable than the goals for the therapy group. The groups did proceed through the five developmental states identified as usually occurring in groups. The amount of influence of the groups was not really tested (Bedger, 1980).

Attitudes about birth control were also studied, and several important implications were drawn from that study. The author stresses the need for research with parents of sexually active teenagers to determine what their attitudes are toward premarital sexual activity and toward the use of contraception by their children. Their attitudes, of course, influence the attitudes of teens. The researchers also state that young women should be helped to recognize that self-control (which most found important) is still exercised by persons using contraception and that using it is a positive step to control future events. They verify Schinke's (1978) contention that birth control information alone is not enough. They state that use of contraceptives is also influenced

by motivation, adolescent changes in thinking and feeling, incorporating the knowledge, resistance from parents, and new problems which may arise, such as environmental or physical changes. All these indicate that continued supportive counseling is necessary (Bedger, 1980).

This study also focused on a group of young women who had second pregnancies during adolescence. They found that attitudes about the second pregnancy were more likely to be negative than about the first pregnancy. The young women were also more likely to drop out of school and have major responsibility for child care after the second delivery. They suggest that those most in need of services are, thus, not reached if the services are connected with the school only. The study also found that a second pregnancy after an infant or fetal loss was likely to occur soon after the termination of the first. This suggests that follow-up counseling to help the young women deal with the first loss is essential so that they may postpone the next conception (Bedger, 1980).

Although this study includes many important implications, its emphasis on rather hazy behavior change outcomes rather than more specific, concrete results makes it hard to generalize about what a good program consists of and what it can accomplish.

A program set up in an all black school in Atlanta was developed with the goal of increasing the participant's rate of continuation in her regular school. With the 1972 HEW policy against excluding pregnant girls from regular school has come the interest in providing services at the regular school of the girls. Those eligible and wishing to participate were assigned a caseworker.

Individual treatment plans were set up and prenatal care, social casework, a reproductive health class and group work were offered. The girls were counseled on their rights to remain in school, and they and their parents were encouraged to do so. The girls in the control group were students attending either of two other high schools in Atlanta which had similar racial and socioeconomic composition to the program high school. The pregnant girls in the control group were either strongly encouraged or were required by their school to withdraw from regular day school and attend night classes at their school when it was discovered they were pregnant. They were allowed to return to regular day classes after delivery. They were offered no special services (Ewer and Gibb, 1976).

The program group had higher rates of return to regular day school at nine months postpartum than the control group, but 62 percent of the control group did return to some type of educational program soon after delivery. 51 percent of the program group returned to their regular day classes and 25 percent of the control group returned. Another 24 percent of the program group returned to some educational program other than their regular school, and another 37 percent of the control group were in an educational program but not their regular day school at nine months postpartum. The authors conclude that "there is a high level of motivation to return to school in the population..." (Ewer and Gibb, 1976, p. 226).

Several studies deal with the children of teen parents. One of the important ones was conducted by Furstenburg (1976) who made an attempt to assess the developmental outcome of the children of

black adolescent mothers in his Baltimore study. The children were tested for cognitive performance and social development at a five year follow-up. He compared the 270 children in the study group who were at least 42 months old to a group of 3-4 year old children of classmates of the adolescent mothers who got pregnant at a later age (approximately age 18 at birth of first child), and three other groups of children of mothers from higher socioeconomic backgrounds. The findings as measured by the Pre-School Inventory did not indicate the children of the young mothers were developmentally delayed. The cognitive development of the children of the adolescent mothers was below that of the children in groups from higher socioeconomic mothers. However, cognitive development in all groups was higher than the national average. There was no significant difference in the interpersonal development of the various groups of children in the study.

Parenting skills of teen mothers are often subject to criticism, and it has been implied that the infants of adolescent mothers frequently end up in the hospital as failure-to-thrive infants or abuse and neglect patients (Sugar, 1976). However, there is no solid evidence to support this (English, 1978). In her study of failure-to-thrive infants, Glaser and team (1968, p. 695) found that the "parents were not teenagers overwhelmed by the strangeness of a first baby but rather adults in their mid-twenties with 2 or 3 children."

A very interesting follow-up study was done on thirty subjects from the Children's Home of Cincinnati in the period from 1971 to 1974. This was not an evaluation of a program but an in-

vestigation of what happened to unmarried women who were under 20 when pregnant, brought their children home from the hospital, were unmarried at the time of the study, and happened to stay at the Children's Home during those three years. For all 30 subjects, 33 percent had less than a high school education, 53 percent had graduated from high school, 13 percent were in college, and 27 percent were studying at the time of the study. In the financial independence category, 60 percent were receiving public assistance, 37 percent were receiving help from the child's father, 27 percent were getting help from parents, 40 percent were employed, and 77 percent had had a job some time since the child's birth. Of the 50 percent living with their parents, 10 percent reported needing counseling, while 50 percent of those living alone said they needed some counseling. Only one of the subjects who reported being sexually active was using no form of contraceptives. Most of those who worked had poorly paying jobs, and most had adequate housing but were financially dependent. The most revealing statistics reported concern of the service priorities the young women listed as needing at the time of the study (Clapp and Raub, 1978):

Service Needed	Percentage Reporting This Need
Child Care	70 %
Financial Assistance	63 %
Employment Counseling	53 %
Babysitting Service	50 %
Educational Counseling	43 %
Parent Education	33 %
Personal Counseling	30 %
Group Meetings with other Unmarried Mothers	30 %
Homemaker Services	27 %
Health Care	27 %
Legal Counseling	20 %

This list seems to substantiate what many evaluation studies point out: long-term goals of educational and employment advancement and financial independence are difficult to attain once a young unmarried woman and her child return to the community.

The key, then, to improving services for adolescent parents is in providing adequate evaluation, discovering effective program elements, and responding to the changes indicated by proper evaluation. To put this review in perspective, however, it is also necessary to note how difficult it is to set criteria for success. Goldstein and his colleagues (1973, p. 79) state this very well,

> "Evaluation of success or failure in the program is difficult. For each student in this program, the criteria for success might be different. For some, simply showing up is tremendous personal victory. For some, exposure to mothering skills and child development lectures might result in no observable sociological improvement in the student, but incalculable improvement in the survival and development of her child."

Thus, we return to the theme that problems, solutions, and evaluation which leads to solutions are all very complex processes. This should not, however, create a negative outlook since effective evaluation can be accomplished and can provide input for change.

CHAPTER III

DESCRIPTION OF THE PROGRAM

HISTORY

In 1967 the Teen Mother Program was started when a public health nurse began working with three to four pregnant young women in Salem, Oregon. They began meeting at the YWCA for prenatal and child care classes. Today the program serves over 150 students each year and the staff includes:

Social Service	Program Director +	10
Education		6
Health		2
Parenting		1
Day Care	Director +	7
Employment		1

The program, which is housed at the YWCA, receives support from the Salem School District, Marion County Children's Services Division, Marion County Family Court, Marion County Mental Health Department, Marion County Public Health Department, and Chemeketa Community College.

The present Teen Mother Program is a comprehensive community based program offering young mothers and pregnant young women Education, Health, Parenting, Day Care, Employment, and Social Services. Besides decreasing the risks for the school-aged mother and

her child, the overall goal of the program is to help the young woman develop into a socially mature and economically self-sufficient person.

ELIGIBILITY

To be considered eligible for admission to the Teen Mother Program, a person must meet the following criteria:

1. Be 18 years old or under when she applies.
2. Live in Marion, Polk, or Yamhill county.
3. Be eligible to attend school in the district where she lives.
4. Be pregnant, recently pregnant, or caring for her own child.
5. Be personally interested in attending the Teen Mother Program.

Students may remain in the Teen Mother Program a total of 18 months.

Perspective students are asked to meet first with one of the counselors to discuss the student's needs and the services offered at the Program. Each component of the program has minimum requirements and each young woman's plan must include a contract to meet these requirements. At the end of each quarter the counselor and student evaluate progress and plan for the next quarter. If the student is not fulfilling her agreement she will be placed on probation and other alternatives will be discussed with her.

EDUCATION

School-age mothers and pregnant young women may attend accredited junior and senior high school classes which meet five days a week from 9:00 a.m. to 2:00 p.m. The Salem School District provides four part-time teachers and one full time teacher for this purpose. Classes in pre- and post-natal health and child development are also provided by the program. In addition, a tutor from Chemeketa Community College helps young women prepare for their GED tests.

Field trips are acknowledged as a means of education; thus, trips are provided around the community and to nearby areas, such as the Oregon coast. Speakers from the community are invited to speak on topics of interest to the young women, thereby adding to their knowledge.

The Salem School District assists in facilitating attendance by providing transportation to and from school, as well as breakfast and lunch for some students. Small classes, teacher interest, and relevant subject matter are offered by the program in an attempt to motivate the young women to continue their education. The goal is to help them stay in school as opposed to dropping out.

HEALTH

To increase the chances of a normal pregnancy as well as to protect the health of both mother and child, the Teen Mother Program offers instruction in prenatal health, childbirth, family planning, family health, child development, and first aid. A

public health nurse is also available for individual consultation, and the Health Department provides well child medical appointments for the babies as well as immunizations, examinations and consultations with a physician.

DAY CARE

A day care center has been made available through the Children's Services Division (CSD). As a result, twenty-five infants and toddlers can be accommodated during the hours the mother attends the program. A director, her staff, and the public health nurse provide consultation.

The facility offers the mothers the opportunity to have contact with their children during the course of the day. It also enables those mothers enrolled in the parenting class to augment their learning experience. Both mothers and pregnant women without children may volunteer to assist in the center.

EMPLOYMENT

The employment counselor is available to all of the young women for job counseling, referrals, and supportive service. She also assists students in completing a self inventory. A resume is completed from this personal appraisal to be used as a job seeking tool. The employment counselor works with the Career Education and Work Experience programs of the Salem Public Schools. Class credit is given for certain types of paid employment.

SOCIAL SERVICES

The program director and a staff of nine full and part-time workers provide individual counseling and supportive services to the young women, young men, and their families. Some of their services are assistance with making doctor, dental, and other appointments, help in finding suitable housing, and seeking solutions for other identified needs. The program utilizes a teamwork approach, thereby making it difficult to define an activity as strictly within the boundaries of a specific service component.

Group therapy is offered through weekly sessions with a male and female facilitator. The emphasis is on improvement of self-image, personal growth, and change. Another group available to the young women is concerned with decision making. The focus is on exploring alternative parenting options and basing decisions on as much information and rational thought as possible.

The ultimate goal of the program is to help the teenage mother become socially mature and economically self-sufficient. Thus, the postponement of subsequent pregnancies, continuation of school, employment, a stable marriage, or return to a stable family situation, could all be termed aspects of success.

PREVIOUS EVALUATION OF PROGRAM

As a result of a request by the 1975 Oregon Legislature, the Children's Services Division completed an evaluation of the Salem Teen Mother Program. This study of the 1975-76 enrollees of the program assessed the impact and effectiveness of the program in

meeting its short-term goals. The final report of the study was submitted to the 1977 Legislature (Children's Services Division, 1976).

The report was generally positive, finding the program effective in such areas as attracting young women and maintaining their participation in the program, reducing maternal and child health risks, identifying and alleviating serious parenting problems, moving the young women to completion of their educational goals, and providing extensive social services that influenced active participation. The report, however, concluded that the program did not have impact on influencing or redirecting the young women's plans for their babies following birth nor on reducing the rate of subsequent pregnancies (Children's Services Division, 1976).

The CSD report did recommend continuation of the program as well as expanded funding, noting the effectiveness of the program in integrating available community services into a comprehensive unit. Along with the continued collection of data assessing the program's short-term goals, the report recommended funds for a follow-up study to assess the lasting effects of the medical, social, and educational aspects of the program on the young women it serves (Children's Services Division, 1976).

CHAPTER IV

METHODOLOGY

PURPOSE

As stated in the description of the program, the goals of the Salem Teen Mother program are to decrease the risk for the teenage mother and her child, and to help young women develop into socially mature and economically sufficient persons. Thus, the program is designed to fulfill the following short-term goals: 1. To increase the chances of normal pregnancies and childbirth, 2. To protect the health of both mother and child, 3. To help the young woman keep up with her studies during pregnancy and to increase the proportion of women who will continue in school following childbirth, 4. To improve the young woman's self-esteem, 5. To help the young woman solve personal problems that have led to or resulted from pregnancy, 6. To decrease the number of future unplanned pregnancies (Teen Mother Program Handbook).

A previous study was conducted by the Children's Services Division (CSD) in response to a mandate by the Oregon State Legislature (See Description Chapter). The objective ot the CSD study was to evaluate the program's effectiveness at meeting stated short-term goals. The study, therefore, focused on outcome measures intended for fiscal considerations.

This present evaluation departs from the earlier CSD study

not so much in content but in focus. Thus, in contrast, this present study is a follow-up study rather than an outcome study of short-term goals. The purpose of the study presently conducted was twofold:

1. To determine the ongoing impact of services to women who have completed the program.
2. To ascertain how the program might improve services.

RESEARCH QUESTIONS

The development of the research questions began with careful scrutiny of the descriptive literature and goal statements of the program. Subsequently, the researchers were provided with lists of questions from administration and key staff of the five service components (education, employment, parenting and day care, health and family planning, and social services). A researcher then met with these key staff in an effort to facilitate familiarization of the program and establish research priorities. These meetings resulted in a better understanding of relevant issues and information necessary to operationally define them. The information gathered developed into assumptions that ultimately became the basis for the research questions. The program assumptions are as follows:

1. Education - The program assumes that young women will drop out of school due to pregnancy. The program provides a specialized curriculum that meets these women's educational needs more effectively than public school.

2. Employment - The program assumes that teen mothers need to develop employable skills; therefore, the program provides opportunities for the teen mother to explore career goals.
3. Parenting and Day Care - The program assumes that teen mothers need to increase knowledge and skill about parenting and provides a realistic approach as well as experience in caring for children.
4. Health and Family Planning - The program assumes that teen mothers need individualized health care education and information. The program provides specialized health care that will reduce health risk to mother and child, and provides health care education and information that will reduce frequency of inappropriate pregnancy.
5. Social Services - The program assumes that teen mothers need a support system that incorporates interpersonal support, social services and provides these services to the teen mother.

See Appendix A for a list of the research questions developed from these program assumptions.

INSTRUMENT DEVELOPMENT

Based on the final statement of research questions, two instruments were developed: a data collection form and an interview schedule (See Appendix A). It should be noted that some of the questions in the survey were not generated from the assumptions;

rather, these items reflect program concerns and information found relevant from the literature review.

A first draft of the interview schedule was presented to the program staff for feedback. Problems relating to lack of clarity and confusing terminology were identified and corrected.

The revised schedule was then administered to five women currently attending the program as a pilot study and resulted in format revisions to facilitate a better flow of the question sequence. The entire research group attended training sessions to develop consensus on the way each question should be asked, and to standardize interviewing techniques and information gathering.

SAMPLING

The population from which the sample was selected included young women who participated in the program during the school years ending in August, 1976; August, 1977; August, 1978; and August, 1979. Contracting was implemented into the program during the 1978 school year. It was anticipated that these four years would provide some comparison data on noncontracting (1976 and 1977) and contracting (1978 and 1979) periods.

A young woman considered eligible for inclusion was placed in the sampling frame if:

1. She had earned 5/8 credit (2½ full classes) in one school semester, and
2. She had been terminated from the program during one of the four years.

This method of defining the sampling frame excluded those

young women whose involvement with the program was either short-term or superficial. It also excluded those young women who are still in the program. If a young woman participated in the program for more than one school year, her name was included in the year she last attended.

Once a complete list of eligible names was obtained for each year, a proportional stratified sample was randomly selected. All names within each subgroup or year were alphabetized and an arbitrary name was selected from which to begin sampling. A sample of 20% was selected from each year. Because it was anticipated that it would be difficult to locate many of the young women selected for the sample, four replacement names were randomly selected for each year. These were intended for use in replacing young women who were known to have moved out of the state. The following table presents the resulting figures:

TABLE I

POPULATION AND STUDY SAMPLE

Year	1976	1977	1978	1979	Totals
Population (N)	40	46	50	35	171
Sample (S)	8	9	10	7	34
Replacements	4	4	4	4	16

Locating

The last known addresses and phone numbers of the young women

and their families proved to be the most successful means of locating those selected for the sample. Staff members of the program also provided additional information on the whereabouts of some young women. Difficulties did develop as a result of unlisted phone numbers and name changes.

Once a young woman was located and contacted by phone, the purpose of the study was explained to her and an appointment for an interview arranged. A letter was then sent to these young women and was signed by Sally Snider, Director of the Teen Mother Program in Salem. This letter again explained the purpose of the study and the importance of their participation in the study (See Appendix B).

If the young women could not be contacted by phone, another letter was sent to what was thought to be a correct address. This letter also was signed by Sally Snider and requested that the young woman return a form with information as to how she could be contacted (See Appendix B). A self-addressed and stamped envelope was included for convenience in returning the form. None of the approximately 10 letters sent were responded to nor resulted in the location of any subjects. Only one was returned to the post office indicating an incorrect address.

Of the total 50 names (first sample plus replacements), 13 could not be located; 7 were found to be residing out of Oregon; 6 could not be contacted by phone or letter; 1 was contacted by phone but refused to participate; and 23 were contacted by phone, agreed to participate, and were interviewed. The following depicts the return rate or percentage of each year's sample contacted and in-

terviewed:

TABLE II

RETURN RATE OF SAMPLE

Year	1976	1977	1978	1979	Total
Sample	12	13	14	11	50
Interviewed	8	8	4	3	23
Percentage Within Year	66.67	61.54	28.57	27.27	46

DATA COLLECTION

Data collection began with the gathering of demographic data. This information was acquired from the educational and social service files of the program. Problems in collecting data from these sources included inconsistent record keeping, as well as a lack of standard forms. The 1978 and 1979 files usually contained necessary information, while the earlier years (1976 and 1977) often did not. Missing demographic information was acquired through the interview process.

Interviewers met with contacted past participants of the program. The interviews took place in Salem, Oregon. Seventeen were held at the Teen Mother Program, two interviews took place at the young women's homes, and four were conducted over the telephone. All interviews were completed within a one month period. Out of a random sample of fifty names, twenty-seven were not available for

interviewing; however, the demographic information collected from these non-respondent files are included in the results.

CHAPTER V

RESULTS

The following results involve data from both the Teen Mother Program files and the questionnaire used to interview 23 of the 50 subjects in the sample drawn. First, demographic data from the program files are used to compare a respondent and non-respondent group. Next, some demographic data from the questionnaire are compared to intake data. Finally, results from each section of the questionnaire are reviewed separately. Where appropriate, a connection is made between the program assumptions, research questions, and questionnaire responses. Also, where appropriate, results are presented in two ways: frequency and percentage.

DEMOGRAPHIC DATA

Demographic Data From the Program Files

The demographic data were retrieved from the intake form found in the social service files at the program. The entire sample population consisted of 50 respondents. We were unable to locate 4 of the 50 files. Consequently, demographics could be retrieved on only 46 of the young women. Of these 46 young women, 24 were located, 23 were interviewed, and the remaining 23 were classified as non-respondents. Despite the fact that 23 of the young women were not located nor interviewed, demographic data were obtained and presented for comparison. Trends and differ-

ences between the two groups are noted in the following discussion. The purpose of the comparison is to determine if the 23 located and interviewed were representative of the whole sample drawn.

Very little difference between the two groups regarding marital status was found. At the time of intake 30 (65%) of the young women in both groups were single. The non-respondents were slightly more likely to be separated than the respondents. Table III shows further information on marital status.

TABLE III

MARITAL STATUS

	Respondent		Non-Respondent		Total	
	f	%	f	%	f	%
Married	6	26	4	17	10	22
Separated	0	0	2	9	2	4
Single	15	65	15	65	30	65
Missing Data	2	9	2	9	4	9
Total	23	100	23	100	46	100

The two groups (respondents and non-respondents) also varied little in living arrangements at the time of intake. Of the 46, 35 (76%) were living in traditional living situations (one or both parents or husband) and of these 35, 10 (22%) were living with a single parent. The non-respondents seemed slightly more likely to be living with a friend or by themselves when they entered the pro-

gram. Table IV shows further information on living arrangement.

TABLE IV

LIVING ARRANGEMENT

	Respondent		Non-Respondent		Total	
	f	%	f	%	f	%
Mother	6	26	4	17	10	22
Both Parents	8	35	9	39	17	37
Husband	5	21	3	13	8	17
Friend	2	9	3	13	5	11
Self	0	0	2	9	2	4
Other	2	9	1	4	3	6
Missing Data	0	0	1	4	1	2
Total	23	100	23	100	46	100

Both groups also seemed to have similar reasons for leaving school. Becoming pregnant was mentioned most frequently by both groups as a reason for leaving public school. This implies that the social stigma and lack of specialized services made it difficult to continue in regular public school. Reasons for leaving are listed below. School problems, as can be noted, were reasons for leaving for only three of the young women.

TABLE V

REASONS FOR LEAVING PUBLIC SCHOOL

	Respondent f	Non-Respondent f	Total f
Pregnancy	17	10	27
Other	5	4	9
Family Problems	1	0	1
Financial Problems	1	2	3
School Problems	1	2	3
Lack of Interest	1	1	2
Missing Data	2	5	7
Total	28*	24*	52*

*Multiple answers were allowed.

No important differences between the two groups were noted as far as contraceptive use is concerned. 30 of the 46 young women used no method of birth control prior to their entry into the program, in contrast to 6 who used birth control pills. 18 respondents were pregnant at the time of intake and using no method of birth control, compared to 11 non-respondents who were pregnant at intake. This difference may have something to do with the age difference in the two groups to be reported in a later section. The non-respondents were slightly older, and more non-respondents had already had their children before entering the program.

Outcome of pregnancy was also an area where only slight differences between the two groups were shown. Eighteen (78%) of the respondents' pregnancies resulted in live, full term birth, compared to fifteen (65%) of the non-respondents. One young woman from each group experienced a spontaneous abortion. Three (13%) of the respondents placed their child for adoption, compared to one (4%) of the non-respondents.

Slight differences in sources of income were also noted. Most frequently mentioned sources of income were family, mentioned by 16 young women; 13 reported they were self-sufficient; and 9 received Welfare. The non-respondents seemed slightly less likely to be supported by their parents and somewhat more likely to be receiving assistance from publicly funded programs. Sources of income are listed in Table VI.

TABLE VI

SOURCES OF INCOME

	Respondent	Non-Respondent	Total f
Parents	10	6	16
Wages	6	7	13
Unemployment	0	1	1
Child Support	0	1	1
Veteran Benefits	1	1	2
S.S. Benefits	0	1	1
Welfare	4	5	9
Other	2	0	2
Missing Data	0	6	6
Total	23	28	51*

*Multiple answers were allowed.

The file information revealed the two groups were both referred to the program by various sources. It is hard to see a conclusive difference, since 10 of the non-respondents had missing data, while only 1 respondent had missing data. Eight of the respondents were referred to the program by someone in their school, compared to 4 of the non-respondents. This is partially explained by data presented later in this section which suggests that respondents were less likely to have dropped out of school. 6 of the respondents lister "other" as a referral source, and 3 of the non-respondents used this category. This category was comprised primarily of family members and other social agencies.

TABLE VII

REFERRAL SOURCES

	Respondent	Non-Respondent	Total f
School	8	4	12
Other	6	3	9
Friend	5	5	10
Health Department	2	1	3
Self	1	1	2
MD/RN	0	2	2
Missing Data	1	10	11
Total	23	26	49*

*Multiple answers were allowed.

One issue indicated by the literature was that adolescent mothers tend to have daughters who also become teen mothers. Our data did not substantiate this. 29 (63%) of the 36 young women in the sample had a mother who was 19 years old or over at the time of delivery, while 8 (17%) of the young women's mothers were under 18 years and considered a teen mother. This data does not reflect a generational trend for teen pregnancy; however, this is not conclusive, since the mother's age at other possible pregnancies could not be determined from our data. Generational data on the mothers of respondents and non-respondents are listed in Table VIII.

TABLE VIII

GENERATIONAL ISSUE

	Respondent		Non-Respondent		Total	
	f	%	f	%	f	%
Under 18 Years	5	22	3	13	8	17
Over 19 Years	16	69	13	57	29	63
Missing Data	2	9	7	30	9	20
Total	23	100	23	100	46	100

Age at entry data indicates a slight difference between the respondents and non-respondents. Of the sample of 46, 21 (46%) were 16 or under at the time of intake. There is a slight ten-

dency for the non-respondents to be older. Table IX shows the remainder of the age at entry data.

TABLE IX

AGE AT ENTRY

	Respondent		Non-Respondent		Total	
	f	%	f	%	f	%
15 Years	6	26	3	13	9	20
16 Years	4	17	8	35	12	26
17 Years	5	22	3	13	8	17
18 Years	3	13	5	22	8	17
19 Years	1	4	3	13	4	9
Over 19	1	4	0	0	1	2
Missing Data	3	13	1	4	4	9
Total	23	100*	23	100	46	100

*Percentage less than 100% due to rounding.

It is difficult to make comparisons of the two groups according to the educational information because it was incomplete on the intake forms. However, 20 of the 46 files had complete data. Of the data recorded, 12 were considered high school drop-outs, and 8 were not. Of the 12 drop-outs, 10 were non-respondents and 2 were respondents. This seems to indicate that the non-respondent group was more likely to have dropped out of public school prior to entering the program than was the respondent group.

One apparent difference between the respondent and non-respondent groups was found with data on grade completed at intake. The non-respondent group had completed fewer grades at intake, while the respondents were closer to completion of their high school curriculum at the time of intake. Table X provided the remainder of the grade completed data.

TABLE X

GRADE COMPLETED AT THE TIME OF INTAKE

	Respondent		Non-Respondent		Total	
	f	%	f	%	f	%
8 or Below	2	9	1	4	3	6
9	5	22	8	35	13	28
10	5	22	7	30	12	26
11	9	39	5	22	14	30
12	0	0	0	0	0	0
Missing Data	2	9	2	9	4	9
Total	23	100*	23	100	46	100

*Percentage greater than 100% due to rounding.

The data from the files, thus, indicate slight differences between respondents and non-respondents. The non-respondents were slightly older, had completed fewer high school grades, and were slightly more likely to be supported by publicly funded programs

rather than their families. However, most data show that the respondent group is fairly representative of the sample of 46.

Demographic Data From the Interview Schedule

Some demographic information was also collected from the interviewees as part of the questionnaire. These questions dealt with present marital status, living arrangement, and disposition of the young woman's child. Differences between intake data and present situation are noted.

Present data indicate a change in marital status for most respondents. Of the 23 subjects surveyed, 15 (65%) were currently married and 8 (34%) were not. In contrast, at the time of intake 6 (26%) of the respondents were married and 15 (65%) were single.

Changes in living arrangement were also noted. Of the sample interviewed, 21 (92%) were living outside of their parents' home (husband, boyfriend, or alone), in contrast to 2 (8%) who were living with their parents or relatives. This is a change from 14 (61%) who were living with one or both parents at the time of intake.

Current data on the child's disposition indicate that of the 23 subjects surveyed 18 (78%) currently have their child living with them, while 3 (13%) placed their child for adoption, 1 (4%) experienced a spontaneous abortion, and 1 (4%) subject's child died of Sudden Infant Death Syndrome.

The remainder of the results fall under specific program headings. Each section of the questionnaire is reviewed in relation to research questions used as a basis for evaluating the pro-

gram.

EDUCATION

The Teen Mother Program assumes that young women who are pregnant or who are parents are more likely to drop out of school. Because of their particular educational needs, a specially designed curriculum will most effectively contribute to their completion of high school and/or return to school after leaving the program.

As can be noted in Table XI, a combined total of 18 (78%) of the respondents completed their high school education (received a diploma or GED) either in the Teen Mother Program or after leaving. A total of 5 (22%) did not complete their high school education.

TABLE XI

COMPLETION OF HIGH SCHOOL EDUCATION

	1976	1977	1978	1979	Total f	Total %
Did Not Complete High School Education	3	0	2	0	5	22
Completed High School Education In TMP	2	5	2	2	11	48
Completed High School Education After TMP	3	3	0	1	7	30
Total	8	8	4	3	23	100

Table XII reports the number of respondents who returned and did not return to school after leaving the program. It is important to note that of the 12 who did not return to school, 8 (67%) of them had received their diploma or GED while in the Teen Mother Program. Of the 8 who returned to high school to complete their education, 2 (25%) of them dropped out before receiving a diploma or GED. For those who continued with their education beyond high school, 1 was enrolled in a school of cosmetology and 3 in college. The 3 in college had attended for either four months, one year, or two years. One of these young women completed high school after leaving the Teen Mother Program and also went on to college. (This accounts for nine responses in 1977.)

TABLE XII

CONTINUATION OF EDUCATION AFTER TEEN MOTHER PROGRAM

	1976	1977	1978	1979	Total f
Continued with High School	5	2	0	1	8
Continued with College or Vocational School	0	3	1	0	4
Did not Continue with School	3	4	3	2	12
Total	8	9	4	3	24

Of the respondents who did not return to school after leaving the Teen Mother Program, the most often stated reasons were: 1) children to raise; 2) employment; and 3) lack of money. Table XIII reports the length of time that those respondents who did return to school remained there. (Data is missing for one respondent.)

When asked if they would like to continue with their education, 21 (91%) of the respondents stated that they would and 2 (9%) stated that they would not. (See Table XXVII in Appendix C.) Table XIV presents the respondents' opinions regarding the influence of the program on their decision to stay in school.

TABLE XIII

LENGTH OF TIME REMAINED IN SCHOOL
AFTER TEEN MOTHER PROGRAM

	1976	1977	1978	1979	Total f	Total %
0 - 3 Months	2	1	0	0	3	30
4 - 6 Months	1	1	1	1	4	40
7 - 9 Months	0	0	0	0	0	0
1 Year	0	1	0	0	1	10
2 Years	1	1	0	0	2	20
Total	4	4	1	1	10	

TABLE XIV

TEEN MOTHER PROGRAM'S INFLUENCE
ON STAYING IN SCHOOL

	1976	1977	1978	1979	Total f	Total %
Yes - TMP had an influence	6	4	2	3	15	65
No - TMP had no influence	2	4	2	0	8	35
Total	8	8	4	3	23	100

When asked to respond to what had made it difficult to attend school at the Teen Mother Program, 17 women responded that nothing had made it difficult. Some stated that they had better attendance while in the program's school than in public school. Of those who stated that there were problems, two mentioned transportation as causing problems in attendance. Other problems, stated only once each, were dislike for classes, children, lack of privacy, and employment. Suggestions offered that might help increase attendance were providing transportation, providing more quiet time, and providing opportunities for better use of free time.

EMPLOYMENT

The Teen Mother Program is based on the assumption that pregnant and parenting young women need to develop employable

skills and be provided with opportunities to explore career goals. Meeting these needs would have impact on the young women's preparation for and obtaining of employment.

20 (87%) of the respondents stated that they had been employed since leaving the program. 3 (13%), one each in 1976, 1978, and 1979, stated that they had not been employed. (See Table XXVIII in Appendix C.)

The respondents reported being employed in many different jobs. The general categories of employment and the number of times each type was mentioned are presented in Table XV.

TABLE XV

TYPES OF EMPLOYMENT AFTER LEAVING TEEN MOTHER PROGRAM

Employment	Number
Office, Clerical, Secretarial, Bookkeeping	11
Food Service, Waitress	8
Unskilled Production	7
Retail Sales	5
Day Care, Nursing Home, or Teacher's Aid	5
Artist	1
Total	37

Of the 20 who had been employed, the total amount of time employed ranged from 10 days to 3 years. The data obtained does not reflect stability of employment but does suggest a trend. As might be predicted, respondents from 1976 have records of being employed generally for the longest periods of time, and the respondents from 1979 have records of employment for shorter periods of time (See Table XXIX in Appendix C).

Of the total respondents, 5 (22%) had been involved in the work experience program (See Table XVI). Of those involved in work experience, all 5 (100%) stated that this program had influenced their choice of work, and 4 (80%) stated it had helped them obtain employment (See Tables XXX and XXXI in Appendix C).

TABLE XVI

RESPONDENTS INVOLVED IN WORK EXPERIENCE PROGRAM

	1976	1977	1978	1979	Total f
Involved in Work Experience	1	3	1	0	5
Not Involved in Work Experience	7	5	3	3	18
Total	8	8	4	3	23

Tables XVII and XVIII present the responses regarding the classes at the Teen Mother Program that taught business skills.

TABLE XVII

RESPONDENTS WHO TOOK CLASSES TEACHING BUSINESS SKILLS

	1976	1977	1978	1979	Total f	Total %
Yes - took classes	6	5	4	3	18	78
No - did not take classes	2	3	0	0	5	22
Total	8	8	4	3	23	100

TABLE XVIII

USEFULNESS OF BUSINESS SKILLS LEARNED

	1976	1977	1978	1979	Total f	Total %
Yes - useful	5	3	3	1	12	67
No - not useful	1	2	1	1	6	33
Total	6	5	4	3	18	100

The respondents who had taken the business skills classes stated these skills were most useful in employment, then at school, and then in the home.

HEALTH AND FAMILY PLANNING

The Teen Mother Program is based on the assumption that specialized health care and education will reduce medical risks to both mother and child. An indicator used to assess lessened health risk is the utilization of some type of health service after leaving the program. Of the entire sample, 16 (70%) received regular health care from a private physician. 5 (22%) utilized the Health Department Clinic and 2 (9%) utilized a private clinic. All respondents stated that they utilized health services on a regular basis.

Use of contraceptive methods after leaving the program was assessed for the entire sample. Of the 23 subjects surveyed, 4 (17%) used no method of birth control, while 1 (4%) was currently pregnant (planned). The type of contraception used by the remaining 18 (78%) of the respondents is listed below.

TABLE XIX

UTILIZATION OF BIRTH CONTROL METHODS

Type	f	%	
Birth Control Pills	9	50	N=18
IUD	4	22	
Foam	1	6	
Surgical (permanent)	2	11	
Rhythm	1	6	
Condom	1	6	
Total	18	101*	

*Percentage greater than 100% due to rounding.

All 20 respondents who reported using contraceptive methods stated that they used the method everytime they engaged in intercourse. It is not clear whether or not there is a respondent bias in reporting use of contraception.

Of the entire sample, 7 (30%) have become pregnant since leaving the program. 3 (43%) of the young women were 18 years old at the time of the subsequent pregnancy, while 4 (57%) were 19 years old and out of the medically defined high risk category. Of the 7 respondents with subsequent pregnancies, 1 (4%) was currently pregnant, while another had had a therapeutic abortion. The remaining 5 (71%) had live, full-term babies with no medical complications reported. Of this sub-population, 6 (86%) received prenatal and/or neonatal care from a private physician while 1 (14%) utilized the Public Health Clinic. All respondents stated that adequate medical care was received. Of these 7 women, 4 (57%) utilized a third-party reimburser for prenatal and neonatal medical care, while 3 (43%) budgeted this expense into their earnings.

Hospitalization was used as a general indicator of health. Of the entire sample, 12 (52%) had not been hospitalized while 11 (48%) had. Only one of these hospitalizations was related to being a high risk teen mother (therapeutic hysterectomy). Hospitalization for both mother and child is listed in tables XX and XXI. Of note is the fact that none of the children were hospitalized for birth related reasons or for any serious illnesses.

TABLE XX

NUMBER OF HOSPITAL ADMISSIONS
(MOTHER)

	1976	1977	1978	1979	Total f	Total %
Hospital Admissions	5	3	3	0	11	48
Not Hospitalized	3	5	1	3	12	52
Total	8	8	4	3	23	

TABLE XXI

NUMBER OF HOSPITAL ADMISSIONS
(CHILD)

	1976	1977	1978	1979	Total f	Total %
Hospital Admissions	2	1	1	1	5	23
Not Hospitalized	5	7	2	2	16	76
Total	7	8	3	3	21*	

*Not applicable for 2 respondents.

Respondents were asked if the prenatal and medical information received while in the program was helpful in caring for their children. Of the 20 respondents who participated in the prenatal and related medical/nutritional classes, 18 (90%) stated that the

information received was adequate and helpful. 2 (10%) of the respondents stated that it was not helpful. Of the sub-sample of seven women who became pregnant, all stated that the prenatal and medical information received was very helpful in caring for their infants.

The respondents who received health supervision for their infants while attending the program were asked if the supervision was adequate and helpful. Of the 15 young women to whom this applied, 12 (80%) stated that the supervision was adequate, while 3 (20%) stated that it was not (See Tables XXXII through XLIII in Appendix C for further health data).

PARENTING AND DAY CARE

With the assumption that young women need to increase knowledge about parenting, the program wished to know how useful the participants found parenting classes. Of the 15 who evaluated the parenting class, 14 found it useful while 1 subject found it not useful. Those who found it useful listed several things it offered: knowledge of child development and needs of children (6); discipline and patience with children (4); help in being a single parent (1); opportunity to share problems and experiences (1); and help in getting a job (1) (See Tables XLIV and ILV in Appendix C).

The helpfulness of the child care program was also of concern. Of the 16 who evaluated the child care program, 15 (94%) found it helpful, and 1 participant (6%) replied that it was not helpful (See Tables XLVI and XLVII in Appendix C).

The program also sought to learn the usefulness of day care

provided. Of the 16 who evaluated day care at Teen Mothers, 14 (87.5%) were pleased with it, while 2 (12%) were not pleased. Of those who were pleased with day care, 9 said it was because of convenience; 3 said it was the only day care available to them; and 1 said it was used in order to attend school. Reasons for <u>not</u> being pleased with TMP day care given by 3 respondents included: the lack of enough teaching aspects for the children; the lack of proper attention to each child; and the child's risk of exposure to illness (See Tables XLVIII and XLIX in Appendix C).

The program also wished to determine what other types of day care were used while in the program and what types young women are currently using. While in the program 2 participants used their immediate family, 1 used a friend, and 1 used another type of day care. Of 20 participants with children, 9 (45%) are using day care at the present time, and 11 (55%) are not. Types being used now include: private babysitter (3); CSD babysitter (2); Headstart Preschool (1); relatives (2); and Teen Mother Program (1). Methods of financing this current day care are: wages (2); CSD (2); free (2); and other (2) (See Table I in Appendix C).

SOCIAL SERVICES

In the area of social services, the program assumes that young women participating in the program need a warm and genuine person to listen to their concerns. Therefore, the program wished to discover to whom the participants turned for support. The results showing sources of support while in the program and present supports are found in the following tables. A shift from staff

support during the program to family support at the present can be noted in Tables XXII and XXIII.

TABLE XXII

SOURCES OF SUPPORT WHILE IN THE PROGRAM

	1976	1977	1978	1979	Total f
Family	3	5	1	0	9
Friends	1	2	1	2	6
Staff	3	4	3	3	13
Others	0	0	0	0	0
No One	2	0	0	0	2
Total	9	11	5	5	30*

*Respondents were allowed to give more than one response.

TABLE XXIII

SOURCES OF SUPPORT AT THE PRESENT

	1976	1977	1978	1979	Total f
Family	7	6	2	2	17
Friends	3	1	1	1	6
Staff	0	0	1	0	1
Others	1	0	0	0	1
No One	0	1	1	0	2
Total	11	8	5	3	27*

*Respondents were allowed to give more than one response.

The program also wished to determine if participation increased goal setting ability. This was not asked directly; however, participants were asked about their present goals and barriers to attaining them. The following table gives their responses:

TABLE XXIV

GOALS FOR THE FUTURE

	1976	1977	1978	1979	Total f
Happily Married	3	0	1	2	6
More Children	3	1	2	2	8
Working on Career	3	6	3	3	15
More Education	4	1	0	1	6
Lose Weight	0	1	0	0	1
Financial Security	0	1	2	0	3
Total	13	10	8	8	39*

*Respondents were allowed to give more than one response.

When asked whether they were presently working on that goal or goals, 13 (56.5%) said they were, and 12 (52.2%) said there were barriers to achieving that goal. Problems in achieving goals included: day care (3); money (9); present marriage (2); pregnant or want to be (2); weight (1); more training needed (1); competition (1); and relocating (1) (See Tables LI, LII and LIII in Appendix C).

PROGRAM CONCERNS

Questions relating to general program concerns dealt with most helpful components, least helpful components, and generally

why the program was of benefit or not, and areas that need improving. The replies concerning the most helpful component in the program can be grouped in several categories.

First of all, a most helpful category is general counseling, staff support, and student support area. Eight respondents mentioned counseling as the most helpful component, and six listed staff support and understanding as most helpful. Five said being with others in the same situation was most helpful. One young woman mentioned as beneficial to her, help in keeping from being involved with the baby's father. One participant saw the program as helping her get away from home.

Another category of most helpful component revolved around education. Six listed a diploma or staying in school as the most helpful. One listed parenting classes, another mentioned good classes in which learning is fun, and another respondent was pleased that teachers let her nurse her baby. Three listed childbirth information as most helpful.

In a category of practical advice and services are the responses of four participants. They listed practical advice information about resources, helping to get child support, helping get jobs, free meals, and free transportation.

In the final category, five respondents listed day care as most helpful. The fact that it was free was important to one participant, and for one young woman the child care program kept her from becoming upset.

When reviewing the least helpful program components, it is important to note that most participants found it difficult to

answer this question. Responses can first be placed in a general education category. Least helpful aspects included: the science program; lack of adequate discussion in parenting class about tantrums and discipline; prenatal class not interesting or relaxed enough; fair-fighting class too authoritarian; all classes too lenient and lacking a more difficult academic focus; school set-up in general; English class; and adequate reading materials.

Other least helpful components included: food; not enough counselors; inadequate counseling around going to school or getting loans or grants; resume writing; lack of YWCA facilities and coordination with other programs; and vocational training work plan.

Participants in the 1978 and 1979 classes evaluated the contracting process. Only seven subjects from these years were located and interviewed. Positive comments about the contracting process included: good structuring of time for serious students; made one young woman take some beneficial classes she wouldn't have otherwise; good idea for some people; and provided motivation. Negative comments included: some parts not necessary, including resume writing; didn't work for some young women; and didn't change motivation level which was already high.

The program wanted to determine if the building presented problems to any of the participants, and the study revealed that 14 (60.9%) of the participants agreed that the setting had faults. Problems identified were: crowding (7); dangerous stairs (4); cafeteria (1); small bathroom (1); and messy rooms (1) (See Table LIV in Appendix C).

In response to what the program could provide that would be helpful after leaving, 12 participants replied nothing; 5 replied counseling; 2 replied follow-up; 1 replied advice concerning problems with children; and 1 suggested a group class on preparing for independent living.

The program assumes that for some teen mothers separate education is more appropriate than public education. The following table shows that 21 (91.3%) believe public school is not better than TMP school.

TABLE XXV

PREFERENCE FOR PUBLIC SCHOOL EDUCATION VS. TMP SCHOOL

	1976	1977	1978	1979	Total f	Total %
Yes	0	1	0	0	1	4.3
No	8	6	4	3	21	91.3
Data Missing	0	1	0	0	1	4.3
Total	8	8	4	3	23	100.0

Problems encountered after the program were varied. Nine participants (39%) listed no problems; 3 listed financial problems; 3 emotional problems; and 2 family problems. The remainder of problems were given by one participant each: social isolation; trouble getting SSI for handicapped child; losing the baby; being

sterile; parenting; finding a job; divorce; and getting into college because TMP credits were recorded inaccurately. It should be noted that some respondents listed more than one problem.

A review of present services which respondents have and services they don't need is found in Tables LV and LVI in Appendix C. Educational counseling (11) and employment counseling (7) are the largest categories of services which respondents indicated they would now like to have, as seen in the following table.

TABLE XXVI

SERVICES YOU WOULD LIKE TO HAVE NOW

	1976	1977	1978	1979	Total f
Child Care	0	2	2	1	5
Welfare	0	1	2	0	3
Employment Counseling	2	1	1	3	7
Babysitting Service	1	3	0	1	5
Educational Counseling	3	5	1	2	11
Parent Education	1	1	1	1	4
Group Meetings With Other Mothers	1	3	1	1	6
Personal Counseling	1	0	0	2	3
Homemaker Services	0	0	0	0	0
Health Care	1	1	2	0	4
Legal Counseling	1	2	2	0	5
Other (WIC and Marriage Counseling)	1	0	1	0	2

The program wished to find out whether participants would be willing to or have already recommended the program to others. Twenty-two would recommend the program to a pregnant friend, no one said they would not, and data is missing for one respondent. Of all participants, twelve (52.2%) have indeed already recommended TMP to a pregnant friend. Fifteen (65%) stated the reason they would recommend TMP is because it offers an opportunity to go to school. Four (17.4%) listed quality of the program as a reason; one respondent (4.3%) said support and child care information were reasons; and three (13%) gave no response (See Tables LVII and LVIII in Appendix C).

Reasons for choosing TMP for themselves also reflect a focus on education. Continuation of school was given as a reason for attending by twelve respondents. Four mentioned that being uncomfortable in public school was a reason. Other reasons included: mother's or family's recommendation (6); day care facilities (2); wanting to be with others in the same situation (3); and because others recommended it (4). It should be noted that some respondents gave more than one reason.

When asked what the program could now help them with, 17 (74.9%) said nothing; 2 (8.7%) said employment; 1 (4.3%) said having reunions; 1 (4.3%) said being included in program parties; 1 (4.3%) said a parenting class; and 1 (4.3%) had no response.

In conclusion, the results from the files and interview schedule indicated that most young women married, had completed high school or received a GED, had not had a subsequent pregnancy, and were pleased with the program. Tables showing these results

have been displayed both within the text of the results chapter and in Appendix C. The following chapter will present conclusions which can be drawn from these results.

CHAPTER VI

CONCLUSIONS

OVERVIEW

This four year follow-up study of the Teen Mother Program was undertaken in 1979 involving participants from 1976 through 1979. This document presents the results from interviews conducted with 23 of the participants plus demographic data from 46 young women in the sample. A systematic sampling procedure, stratified by years was used to select the sample. The interview was constructed to provide follow-up information about all five components of the program.

LIMITATIONS

It is necessary to note several important limitations of this study. First of all, location of subjects was a difficult and delimiting process. Of the 50 subjects drawn, 24 were located, and 23 agreed to be interviewed at the program, in their homes, or by phone. It is possible that those found and agreeable to the interview were the more "successful" graduates. Since the nature of the current status of the non-respondent group is not known, the non-response bias is a limitation which must be considered.

Secondly, another overall limitation is that this is a follow-up study. We have no control group which could provide causal

linkages between outcomes and program influences. In some cases we have asked subjects whether the program influenced them in a particular area, but even this cannot be construed as a causal relationship.

Finally, lack of thorough interviewer training may have caused some inconsistencies in the data collection. Nevertheless, the study provides an evaluation of the program which can be considered to be valid. With these limitations in mind, the following conclusions can be drawn from the study.

DEMOGRAPHIC DATA

Demographic information was compiled from program files for both respondents and non-respondents, a total of 46 young women. It was found that the respondent group was generally similar to the non-respondent group.

Overall, conclusions drawn from this demographic data should be reviewed tenuously. However, a general picture of a typical participant can be outlined. At the time of intake, most of the young women from the sample years 1976 - 1979 were 16 years of age or under, single, and supported by and living with one or both parents. The most frequently mentioned reason for leaving public school was their pregnancy, and the program provided the opportunity for these young women to complete their high school education.

Demographic data was also collected from the interview schedule and compared with the intake data. Of the 23 young women interviewed, the majority were married, living independently of their parents and had their children living with them. In com-

parison to the data collected at intake, there appears to have been a transition from adolescents being dependent upon their parents to young adults who are self-sufficient.

EDUCATION

The Teen Mother Program is a comprehensive program with education as a major focus. One of the stated goals is to keep the young woman in school and to help her obtain a high school diploma. The findings of this study reveal that 48 percent of those young women interviewed did obtain either a high school diploma or GED while in the program; 30 percent received their high school diploma after leaving the program. Furthermore, 65 percent of the young women interviewed reported that the program influenced their decision to remain in school. Therefore, these findings would seem to indicate the program was successful in meeting this educational goal.

This study also revealed a low drop-out rate among those young women interviewed who returned to regular school. Of this returning group, 75 percent remained until they received their high school diploma. Most of the programs reviewed in the literature were not successful in reducing high school drop-out rate. In her evaluation of the Webster School, Howard (1968) found that one-third of the young women returning to regular school dropped out prior to graduation. Studies undertaken by Klerman and Jekel (1973) and Harrison (1972) present similar findings with respect to the drop-out rate.

However, the 1976 Ewer and Gibb study of school return among pregnant girls found that the majority of girls in their control and study groups returned to school of some type. They concluded that there was a high level of motivation for gaining an education in the population. While it appears that the Teen Mother Program may have been a factor in low drop-out rate, one needs to consider that these girls may also have been highly motivated to continue in school. As one young woman stated, "I wanted to graduate really bad, and the program made it possible to attend school and get my diploma. I don't know if I could have done it otherwise." The young women identified small class size and individualized attention as other factors contributing to their continuing in school while at the Teen Mother Program. Therefore, it can be construed that the program appears successful in meeting the needs of those young women desiring to finish their high school education.

EMPLOYMENT

Another goal stated by the Teen Mother Program is to increase the young women's employability. One way in which the program attempts to meet this goal is by providing business skills classes. The data obtained shows that 78 percent of the young women interviewed had taken these classes. Of that group, 66 percent stated that they found them useful in terms of employment, school, and home. Further data shows that the greatest number of these young women were employed in office type jobs; i.e., clerical, secretarial, and bookkeeping. This would seem to indicate

that many of the young women were able to utilize business skills they acquired at the program. Therefore, it can be inferred that the program was effective in increasing employability for many of the young women interviewed.

Data obtained from this study revealed a high employment rate for the young women interviewed. A majority, 87 percent, of the respondents had been employed for some time since leaving the program. An interesting finding is that many of these women were employed in low paying, low skill jobs. This finding concurs with data obtained in a follow-up study of the Children's Home of Cincinnati (Clapp and Raub, 1978) which also showed that many of the participants ended up in low paying, low skilled jobs. A general consensus from the literature is that teenage pregnancy is not necessarily the cause of this; rather the age of the girl, her previous work experience, and the condition of the labor market are critical factors (Chilman, 1978).

PARENTING AND DAY CARE

The objective of the parenting class was to increase the knowledge and skills of the young women enrolled. Findings indicate that most of the respondents found the class useful. Responses from the participants at follow-up were generally positive. As one young woman stated, "It helped me understand my child." Another said, "It gave me more ideas how to control my child - - how to reason with him instead of fight with him." Another responded, "I learned about the developmental stages of a child."

Thus, it can be inferred that the parenting class is meeting the needs of the young women interviewed.

Day care is funded by CSD and provided by the Teen Mother Program so that young women may find it easier to attend school and complete their education. The importance of day care to the teenage mother cannot be underestimated. Most of the studies examined in the review of the literature found that the lack of day care meant forced interruption of school or financial dependence from which many young girls could not extricate themselves (Guttmacher Inst., 1976).

Participants of the Teen Mother Program also indicate that help with child care was a critical factor in their ability to attend the program. The importance of day care at the program is illustrated by the following quotes: "Without day care I couldn't have gone to school"; "There was no other way to pay for child care."

HEALTH SERVICES

The purpose of health services is to help the young woman care for herself and her family by learning about health needs. The program attempts to fulfill this by educating the young women in utilizing health services while they are in the program. A long-term goal is that the women will continue to use existing health services when they leave the program. At follow-up, all respondents stated they are utilizing medical services on a regular basis for both themselves and their children. It is interesting to note that most of the services are provided by private practitioners.

Another concern addressed by the program is that of subsequent unplanned pregnancies. Follow-up indicates that 7 pregnancies occurred after leaving the program. These were identified as being "planned" by the respondents. The women were all over age 18 at the time of pregnancies; thus, they cannot be classified in the "high risk" category.

Follow-up data revealed that 78 percent of the young women use contraception; of those, 100 percent profess to using contraception "all of the time." It should be mentioned that several young women use methods considered to be less effective, according to Chilman (1978). Findings showed that many did not use contraception prior to admission to the program. The contrast in use of contraception at entry and at the follow-up might be attributed to the influence of sex education information provided at the program; however, it must be noted that Chilman's (1978) review of adolescents' use of contraception indicated that the maturation process was also an important factor in contraception use.

SOCIAL SERVICES

The Teen Mother Program seeks to provide as part of social services, counseling and support services for the young women. The results of this study indicate that the women did indeed utilize the Teen Mother staff for support while attending the program. Likewise, at follow-up most of the respondents reported the family as a primary source of support.

Other facets of the program emphasize self-awareness and exploration of alternatives for present and future life styles. With

this in mind, the study questioned the young women about their future goals. Most of the respondents said that they desired a career within the next five years, while a smaller number stated they wanted to be happily married.

PROGRAM CONCERNS

Responses to a question about the most helpful components of the program fell into three general areas. The largest number of responses from the young women pointed to the general support category as the most helpful component. Included in this category were: counseling and support from staff; and support from those peers at the program with like situations. It can be assumed, then, that the young women interviewed saw social and emotional support provided by the program as the most helpful program element.

A second most helpful element of the program mentioned by the young women interviewed was education. Over half of the respondents designated opportunity to continue school as a reason for choosing the Teen Mother Program. Fifteen of the 23 interviewees also noted that they had recommended the program to other pregnant school girls for the same reason.

The day care and child care components of the program were seen as the third most helpful aspects. Comments from some of the participants indicating that they could not have attended without the day care provision is important information.

The least helpful components, although difficult for most respondents to delineate, were much more specific in nature. Most of

the criticisms concerned a specific aspect of one of the program components; such as, a particular class not suiting them personally, not enough counselors, resume writing, and food. It might be concluded from this that at least most of those interviewed did not see a weak component, but found specific areas which they felt needed improvement.

Several sections of the interview dealt with what problems the young women have experienced after termination and what follow-up services might be helpful. Over half the respondents did not see themselves as having problems or as having only limited problems. They generally felt that no follow-up services or present help from the program was necessary. Drawing from those responses indicating that some follow-up services would be beneficial, it can be concluded that the service most desired is counseling in three areas: education, employment, and personal. Financial dependence, subsequent unplanned pregnancies, and other serious problems often associated with teenage parenthood and found in the evaluations of programs discussed in the literature were absent in this group of women.

Helpful information gleaned from this study concerns the practice of providing separate schools for pregnant school girls. Several authors, cited in the literature review, questioned whether pregnant teens should be removed from regular public school. This follow-up study showed that the young women overwhelmingly agreed that a separate school was better for them.

If the program wished to judge its merits on whether participants recommend it to others, the group interviewed gave the pro-

gram high marks by stating almost unanimously they would recommend it to others. This is also reinforced by the opinion of all eight interviewers that respondents were enthusiastic about the program and what it had done for them.

In conclusion, the goals of the program seem consistent with the needs expressed by the young women. The data suggests that the program is having continued impact on the women after they leave the program. This is supported by their aspirations for continuing education and employability.

The Teen Mother Program, when compared to other programs discussed in the literature review, seems to be more than adequately meeting the needs of its pregnant teenage participants.

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APPENDIX A

RESEARCH QUESTIONS

I. EDUCATION

T.M. Program assumes that teen mothers/young pregnant women will drop out of school due to pregnancy. Also, program assumes that a specialized designed curriculum meets these women's educational needs more effectively.

A. Had young women dropped out of school prior to entering program.

B. Young pregnant women/teen mothers do not attend public school because they are pregnant.

C. How effective was program in securing clients' return to regular school and/or continuance until graduation.

1. How many clients received diplomas or GED while in program?
2. How many clients returned to school after leaving the program?
3. How long did young women stay in school?
4. How many clients received diplomas or GED after leaving the program?
5. What were the reasons for not returning to school?
6. How many clients received post high school education? What kind? How much?

D. What impact did program have on securing further ed/voc training.

II. EMPLOYMENT

T.M. Program assumes that clients need to develop employable skills. Program provides opportunities to explore career goals.

A. Did the program have impact in obtaining employment and/or preparing client for employment.

1. Has client been employed since leaving the program?
   1.1 Type of employment.
   1.2 Length of employment.
2. Was client involved in work experience program?
   2.1 Did this experience influence choices of occupation?
   2.2 Did this experience lead directly to obtaining employment?
3. Did client participate in clerical skills classes?
   3.1 Were the skills used?

III. HEALTH/FAMILY PLANNING

Program assumes that pregnant women/teen mothers need individualized health care education/information care. Program assumes that specialized health care will reduce health risks to mother and child. Health care education/information will reduce frequency of inappropriate pregnancy.

A. Impact of health care education.

1. How does client utilize existing community health services?
   1.1 Does client have a family doctor?
   1.2 Does client attend a clinic?
2. Type of contraceptive used?
   2.1 Used on regular basis?
   2.2 Did program provide this?
3. Has there been an unplanned pregnancy since leaving program?
4. Given a subsequent pregnancy,
   4.1 Was client still in "high risk"?
   4.2 Outcome of pregnancy (keep, adopted)?
   4.3 Type of medical care received?
   4.4 Financing of medical care?
   4.5 Complication of pregnancy?
5. Did program provide adequate medical information?
6. Did program provide adequate nutritional information?
7. Was information helpful in subsequent pregnancy?
8. Current health of mother?
9. Current health of child?

IV. PARENTING/DAY CARE

A. Young women need to increase knowledge/skill about parenting. The program provides a realistic approach as well as experience in caring for children.

1. Did you participate in parenting class?
   1.1 Was it useful?

B. T.M. need realistic approach and experience in caring for their children.

1. Did you participate in child care program?
   1.1 Was experience helpful?

C. Impact of day care program.

1. Did you use day care?
2. Was day care adequate?
   2.1 Were you pleased with day care?
   2.2 Why?
3. Was there other day care available?
   3.1 Relatives, friends, other day care?
4. Why did you use program day care?

V. SOCIAL SERVICE

A. The program assumes that teen mothers need a support system that incorporates interpersonal support, social services and provides these services to the teen mother.

1. While in the program, who was supporting?
   1.1 Family, friends, peers, staff?
   1.2 Who do you get your support from now?

B. Does program increase goal setting ability?

1. Did program supply helpful ways to solve problems?
2. Is it easier to make decisions about your life goals?
   2.1 Do you have a goal you would like to achieve in the next five years?
   2.2 What are barriers?
   2.3 Are you working on achieving goal presently?

VI. PROGRAM CONCERNS

A. What was most helpful about program?

1. What was least helpful about program?

B. How do you feel about contracting process?

C. Were there problems with facility?

1. List.

D. What else might program provide that would be helpful after leaving?

E. Would public school education be better alternative to program education?

F. List problems in reentering the community, if any.

G. Would you recommend program to a pregnant friend?

   1. Have you?

H. Who referred client to the program?

I. What were reasons in choosing T.M. Program?

INFORMED CONSENT

I, _____, hereby agree to participate in the research project on young women who have attended the Teen Mother Program.

I understand that I will be interviewed about what I have been doing since I left the program and how I felt about the program while I was in it. _____ has offered to answer any questions I may have about the study and what is expected of me.

I understand that I am free to withdraw from participation in this study at any time without jeopardizing my relationship with Teen Mother Program.

I have read and understand the foregoing information.

Signature _____ Date _____

INFORMATION FROM CASE RECORD

Length of stay in program:

Source of income during program:

Disposition of child:

Any involvement with CSD:

Contracting?

Other Important Information:

PERSONAL & FAMILY INFORMATION

Name_____ DOB __/__/__ Age at Entry _____

Age of Natural Mother _____ DOB __/__/__

Marital Status:

Married	___
Separated	___
Widowed	___
Divorced	___
No. of Marr.	___

Living Arrangements:

Mother	___	Husband	___
Father	___	Friend	___
Both	___	Self	___
Foster	___	Other	___

EDUCATIONAL INFORMATION

School Still Attending _____
School Last Attended _____
Date Last Attended _____
Grade Completed _____

Reasons for Leaving:

Illness	___
Pregnancy	___
No Day Care	___
Family Probs	___
Financial Probs	___
School Probs	___
Lack of Interest	___
Other	___

MEDICAL INFORMATION

BCM:	Prev.	Pres.	Fut.
IUD	_____	_____	_____
Pills	_____	_____	_____
Diaph	_____	_____	_____
Condom	_____	_____	_____
Foam	_____	_____	_____
Surg.	_____	_____	_____
Preg.	_____	_____	_____
None	_____	_____	_____
Other	_____	_____	_____

Outcome of Preg.	#1	#2	#3
Live (full term)	___	___	___
Live (<5½ lbs.)	___	___	___
Stillbirth	___	___	___
Therap. Abortion	___	___	___
Spont. Abortion	___	___	___
Adoption	___	___	___

Infant: Birth Wt. ___lbs.___ oz.
Premature? _____

Mother: (indicate any items checked re: pregnancy and delivery).

FINANCIAL AND GENERAL INFORMATION

Sources of Income:

Parents	___	Vet. Benefits	___
Wages	___	SS Benefits	___
Unemployment	___	Welfare	___
Child Support	___	Other	___

Referred by:

School	___
Health Dept.	___
Self	___
Friend	___
MD/RN	___
Other	___

TEEN MOTHER PROGRAM SURVEY

CASE # _____

Hi, I'm _____, one of the volunteers from the YWCA. I am here conducting a survey and will be asking you some questions. These questions will deal with your experience while in the Teen Mother Program and how you have been doing since leaving the program. We need this information to make improvements in our services so we really need to know how you feel. I want you to know that this survey is strictly confidential and your answers will help us make these improvements, okay? I'll begin the questioning then .....

1. How old are you now? _____
2. Are you currently married? Yes ____ No ____
3. Who are you presently living with?

   Husband ____ Parents ____ Relatives ____

   Friends ____ Boyfriend ____ Alone ____
4. Has your living situation changed since leaving the program?

   Yes ____ No ____
5. Is _____ living with you now?

   Yes ____ No ____

   If no, where is he/she living?

   Adopted ____ Foster Home ____ Grandparents ____

   Other Relatives ____ Friends ____ Child's Father ____

EDUCATION

1. a.) Did you return to school after leaving the Teen Mother Program?

   Yes ____ No ____ If no go to b.
   If yes go to c.

   b.) How come? (Could you tell me more about that?)

   c.) How long did you attend the school? _____

2. a.) Have you received your GED or diploma since leaving the Teen Mother Program?

   Yes ____ No ____ If no, did you receive it in the program? _____

3. a.) Would you like to continue with your schooling?

   Yes ____ No ____

   b.) Did the program have anything to do with your decision to stay in school?

   Yes ____ No ____

4. a.) What made it hard to go to the Teen Mother school and stay there?

   b.) Is there anything the program could have done to help you come to school more regularly?

EMPLOYMENT

1. a.) Have you been employed since leaving the program?

   Yes ____ No ____

   b.) What type of employment?

   c.) How long were you employed?

2. a.) Were you involved in the work experience program?

Yes ____ No ____ If no go to 3.
If yes go to b.

b.) Did this program influence your choice of work?

Yes ____ No ____

c.) Did this experience help you get work? Yes ____ No ____

3. a.) Did you take any classes that taught you business skills?

Yes ____ No ____

b.) Have you used those skills? Yes ____ No ____

If yes, where did you use these skills? (list)

HEALTH AND FAMILY PLANNING

1. a.) Where do you get your health services?

2. a.) Have you been in the hospital since leaving the program?

Yes ____ No ____

b.) Has your child been hospitalized? Yes ____ No ____

If yes, discuss.

3. a.) Have you been pregnant since leaving the Teen Mother Program?

Yes ____ No ____ If no go to 6.
If yes go to b.

b.) What was your age at the time of the other(s) pregnancy?

_____

c.) Were there any medical problems during your pregnancy?

Yes ____ No ____ If yes, please specify.

d.) Outcome of pregnancy: #1 #2 #3

(1) Live (full-term) ___ ___ ___

(2) Live (<5½ lbs.) ___ ___ ___

(3) Stillbirth ___ ___ ___

(4) Therapeutic Abortion ___ ___ ___

(5) Spontaneous Abortion ___ ___ ___

e.) Date of birth: _____ _____ _____

f.) Birth Weight: ___lbs___oz ___lbs___oz ___lbs___oz

g.) Premature: Yes___ No___ Yes___No___ Yes___No___

4. a.) During your other(s) pregnancy, what kind of medical care did you get?

Hospital ____ How often_____ Doctor ____ How Often_____

Clinic ____ How Often_____ None _____

b.) How was your medical care financed?

5. a.) Was the prenatal and medical information given in the program helpful in other(s) pregnancies?

Yes ____ No ____

6. a.) While you were in the program did you find the prenatal information helpful (diet, rest, etc.)?

Yes ____ No ____

7. a.) Did the program provide helpful health supervision for your child (earaches, stomachaches, etc.)?

Yes ____ No ____

8. a.) Are you using any method to keep from getting pregnant at the present time?

Yes ____ No ____

b.) What method are you using?

(1) IUD ____

(2) Pills ____

(3) Diaphragm ____

(4) Condom ____

(5) Foam ____

(6) Surgical ____

(7) Pregnancy ____

(8) Other (withdrawal) ____

c.) Do you use this method of birth control or contraception absolutely everytime or just sometimes?

Everytime ____ Sometimes ____

PARENTING AND DAY CARE

1. a.) Did you participate in the parenting class?

Yes ____ No ____

b.) Was it useful?

Yes ____ No ____ If yes, how?

2. a.) Did you work in the child care program?

Yes ____ No ____

b.) Was this experience helpful? Yes ____ No ____

3. a.) Did you use day care at the Teen Mother Program?

Yes ____ No ____ If yes, why did you choose to do so?

b.) Were you pleased with the day care?

Yes ____ No ____ If no, why?

4. a.) If you did not use Teen Mother day care, what did you use?

Immediate Family ____ Neighbors ____ Friends ____

Child's Father ____ Other Relatives ____ Other ____

5. a.) Are you currently using day care?

Yes ____ No ____ If yes, what type?

b.) How do you pay for this (day care)?

SOCIAL SERVICES

1. a.) While in the program, when you were upset, who would you talk to?

Family ____ Friends ____ Staff ____ Others ____

b.) Who do you turn to most often now?

Family ____ Friends ____ Staff ____ Others ____

PROGRAM CONCERNS

1. a.) What was most helpful about the Teen Mother Program?

b.) What was least helpful about the program?

2. a.) (For 1978, 1979 ONLY)...How do you feel about the contracting process?

3. a.) Were there problems with the building?

Yes ____ No ____ If yes, please list the problems.

4. a.) What else might the program provide that would be helpful after leaving?

5. a.) Do you think that public school would have been better than Teen Mother School?

Yes ____ No ____

6. a.) What kinds of problems did you have after leaving the program?

b.) Tell me about the services you have now.

Service	Have	Would Like	Don't Need
Child Care	____	____	____
Welfare	____	____	____
Employment Counseling	____	____	____
Babysitting Service	____	____	____
Educational Counseling	____	____	____
Parent Education	____	____	____
Group Meetings with Other Mothers	____	____	____
Personal Counseling	____	____	____
Homemaker Services	____	____	____
Health Care	____	____	____
Legal Counseling	____	____	____
Other	____	____	____

7. a.) Would you recommend the Teen Mother Program to a pregnant friend?

   Yes ____ No ____ Why?

   b.) Have you recommended the program to a pregnant friend?

   Yes ____ No ____

8. a.) What were your reasons in choosing the Teen Mother Program?

9. a.) If you could see yourself 5 years from now, what would you be doing?

   b.) Are you working on that goal now? Yes ____ No ____

   (Specify the goal that they are working on.)

   c.) Are there any problems in achieving that goal?

   Yes ____ No ____

10. a.) Is there anything the Teen Mother Program can help you with now?

Teen Mothers Program

YWCA

768 State Street
Salem, Oregon 97301

503 / 581-9922

APPENDIX B

Hi! We have been trying to contact you to ask you for your help. We want to ask you some questions so that we can make the Teen Mothers Program better for young women and their families. We would like to know something about how you've been doing since you left the program, whether you're still in school, and whether you might be working. You are the best judge of how helpful the program was to you. The questions the volunteer will ask you will be kept confidential. The purpose is only to see how the services may have helped you reach some of your goals.

Would you please fill out the attached form and return it if you're willing to help us out. Please call Craig or Dennie Schreiter at the Teen Mothers Program if you have any questions. Their number if 581-9922. The program is able to pay you for mileage at the rate of 15¢ per mile to come to the program to answer the questions. If it is not possible for you to come to the program, the volunteers are also able to set up a home visit.

We appreciate very much your taking part in this project, because you are the best source of help for future teen mothers. We hope to see you soon.

Sincerely yours,

Sally Snider
Salem Teen Mother Program

- -

Your name_____ Phone number_____

Current address_____

_____

Teen Mothers Program

YWCA

768 State Street
Salem, Oregon 97301

503 / 581-9922

Hi! You have probably received a call from one of our volunteers asking for your help. We want to ask you some questions so that we can make the Teen Mothers Program better for young women and their families. We would like to know something about how you've been doing since you left the program, whether you're still in school, and whether you might be working. You are the best judge of how helpful the program was to you.

The questions the volunteers will ask you will be kept confidential. The purpose is only to see how the services may have helped you reach some of your goals. Please call Craig or Dennie Schreiter at the Teen Mothers Program if you have any questions. Their number is 581-9922.

We appreciate very much your taking part in this project because you are the best source of help for future teen mothers. We hope to see you soon.

Sincerely yours,

Sally Snider
Salem Teen Mother Program

APPENDIX C

EDUCATION

TABLE XXVII

RESPONDENTS' PRESENT DESIRE TO CONTINUE WITH EDUCATION

	1976	1977	1978	1979	Total f	Total %
Yes - Want to Continue	7	8	4	2	21	91
No - Do Not Want to Continue	1	0	0	1	2	9
Total	8	8	4	3	23	100

EMPLOYMENT

TABLE XXVIII

RESPONDENTS EMPLOYED SINCE LEAVING TEEN MOTHER PROGRAM

	1976	1977	1978	1979	Total f	Total %
Yes - Employed	7	8	3	2	20	87
No - Unemployed	1	0	1	1	3	13
Total	8	8	4	3	23	100

TABLE XXIX

TOTAL LENGTH OF TIME EMPLOYED SINCE LEAVING TEEN MOTHER PROGRAM

	1976	1977	1978	1979	Total f	Total %
1 - 3 months	0	1	0	1	2	10
4 - 6 months	0	0	0	0	0	
7 - 9 months	0	1	0	1	2	10
10 - 12 months	1	1	1	0	3	15
13 - 18 months	2	2	2	0	6	30
19 - 24 months	2	0	0	0	2	10
More than 24 months	2	3	0	0	5	25
Total	7	8	3	2	20	100

TABLE XXX

INFLUENCE OF WORK EXPERIENCE ON RESPONDENTS' CHOICE OF WORK

	1976	1977	1978	1979	Total f	Total %
Yes - Did Influence	1	3	1	0	5	100
No - Did Not Influence	0	0	0	0	0	
Total	1	3	1	0	5	100

TABLE XXXI

IMPACT OF WORK EXPERIENCE ON RESPONDENTS' OBTAINING EMPLOYMENT

	1976	1977	1978	1979	Total f	Total %
Yes - Helped	1	2	1	0	4	80
No - Did Not Help	0	1	0	0	1	20
Total	1	3	1	0	5	100

HEALTH AND FAMILY PLANNING

TABLE XXXII

UTILIZATION OF HEALTH SERVICES

	1976	1977	1978	1979	Total f	Total %
Private Physician	6	7	1	2	16	70
Health Department Clinic	1	0	3	1	5	22
Private Clinic	1	1	0	0	2	9
Total	8	8	4	3	23	

TABLE XXXIII

SUBSEQUENT PREGNANCIES

	1976	1977	1978	1979	Total f	Total %
Became Pregnant	4	2	1	0	7	30
Did Not Become Pregnant	4	6	3	3	16	70
Total	8	8	4	3	23	

TABLE XXXIV

AGE AT SUBSEQUENT PREGNANCY

	1976	1977	1978	1979	Total f	Total %
18	1	2	0	0	3	43
19 or over	3	0	1	0	4	57
Total	4	2	1	0	7	

TABLE XXXV

MEDICAL PROBLEMS DURING SUBSEQUENT PREGNANCIES

	1976	1977	1978	1979	Total f	Total %
Yes	0	0	0	0	0	
No	4	2	1	0	7	100
Total	4	2	1	0	7	

TABLE XXXVI

OUTCOME OF SUBSEQUENT PREGNANCY

	1976	1977	1978	1979	Total f	Total %
Live (full-term)	3	2	0	0	5	71
Therapeutic Abortion	1	0	0	0	1	14
Currently Pregnant	0	0	1	0	1	14
Total	4	2	1	0	7	

TABLE XXXVII

UTILIZATION OF HEALTH SERVICES
DURING SUBSEQUENT PREGNANCY

	1976	1977	1978	1979	Total f	Total %
Private Physician	3	2	1	0	6	87
Health Department Clinic	1	0	0	0	1	14
Total	4	2	1	0	7	

TABLE XXXVIII

FINANCING OF SUBSEQUENT PREGNANCIES

	1976	1977	1978	1979	Total f	Total %
Wages	3	0	1	0	4	57
Insurance	0	2	1	0	3	43
Total	3	2	2	0	7	

TABLE XXXIX

USEFULNESS OF PRENATAL/MEDICAL INFORMATION IN SUBSEQUENT PREGNANCY

	1976	1977	1978	1979	Total f	Total %
Helpful	3	2	2	0	7	100
Not Helpful	0	0	0	0	0	
Total	3	2	2	0	7	

TABLE XL

USEFULNESS OF PRENATAL/MEDICAL INFORMATION FOR ENTIRE SAMPLE

	1976	1977	1978	1979	Table f	Table %
Helpful	5	6	4	3	18	78
Not Helpful	2	0	0	0	2	9
Total	7	6	4	3	20*	

* 3 respondents did not participate.

TABLE XLI

ADEQUACY OF HEALTH SUPERVISION

	1976	1977	1978	1979	Table f	Table %
Helpful	3	5	2	2	12	75
Not Helpful	2	1	1	0	4	25
Total	5	6	3	2	16*	

* 7 respondents did not participate.

TABLE XLII

CURRENT USE OF CONTRACEPTION

	1976	1977	1978	1979	Total f	Total %
Using Some Method	6	6	3	3	18	78
Using No Method	2	2	1	0	5	22
Total	8	8	4	3	23	

TABLE XLIII

CONSISTENCY OF CONTRACEPTION USE

	1976	1977	1978	1979	Total f	Total %
Everytime	7	5	4	3	19	100
Sometimes	0	0	0	0	0	
Total	7	5	4	3	19*	

* Not applicable for 4 respondents.

PARENTING

TABLE XLIV

PARTICIPATION IN PARENTING CLASS

	1976	1977	1978	1979	Total f	Total %
Yes	5	6	3	2	16	70
No	3	2	1	1	7	30
Total	8	8	4	3	23	100

TABLE XLV

USEFULNESS OF PARENTING CLASS

	1976	1977	1978	1979	Total f	Total %
Yes	4	5	3	2	14	93.3
					N=15*	
No	1	0	0	0	1	6.7
Not Applicable	3	3	1	1	8	
Total	8	8	4	3	23	

* N=number of participants evaluating parenting class.

TABLE XLVI

PARTICIPATION IN THE CHILD CARE PROGRAM

	1976	1977	1978	1979	Total f	Total %
Yes	8	2	3	2	15	65
No	0	6	1	1	8	35
Total	8	8	4	3	23	100

TABLE XLVII

USEFULNESS OF THE CHILD CARE PROGRAM

	1976	1977	1978	1979	Total f	Total %
Yes	8	2	3	2	15	94 N=16*
No	0	1	0	0	1	6
Not Applicable	0	5	1	1	7	
Total	8	8	4	3	23	

* N=number of participants evaluating child care program.

TABLE XLVIII

PARTICIPATION IN TEEN MOTHER PROGRAM DAY CARE

	1976	1977	1978	1979	Total f	Total %
Yes	4	5	2	2	13	56.5
No	3	3	2	1	9	39.0
Not Applicable	1	0	0	0	1	4.3
Total	8	8	4	3	23	100

TABLE XLIX

PLEASED WITH TEEN MOTHER PROGRAM DAY CARE

	1976	1977	1978	1979	Total f	Total %
Yes	5	4	3	2	14	87.5
					N=16*	
No	0	1	1	0	2	12.5
Not Applicable	3	3	0	1	7	
Total	8	8	4	3	23	

* N=number of participants evaluating day care.

TABLE L

CURRENT USE OF DAY CARE

	1976	1977	1978	1979	Total f	Total %
Yes	3	3	2	0	8	45
					N=20*	
No	3	5	2	2	12	55
Not Applicable	2	0	0	1	3	
Total	8	8	4	3	23	

* N=number of participants with children.

SOCIAL SERVICES

TABLE LI

WORKING ON GOAL PRESENTLY

	1976	1977	1978	1979	Total f	Total %
Yes	3	5	4	1	13	56.5
No	5	3	0	2	10	43.5
Total	8	8	4	3	23	100

TABLE LII

PROBLEMS IN ACHIEVING GOAL

	1976	1977	1978	1979	Total f	Total %
Yes	2	7	2	1	12	52.2
No	5	1	2	2	10	43.5
Data Missing	1	0	0	0	1	4.3
Total	8	8	4	3	23	100

TABLE LIII

TYPES OF PROBLEMS IN ACHIEVING GOAL

	1976	1977	1978	1979	Total f
None	5	1	1	2	9
Day Care	1	2	0	0	3
Money	1	5	1	1	8
Present Marriage	1	1	0	0	2
Weight	1	0	0	0	1
More Training Needed	0	1	0	0	1
Competition	0	0	1	0	1
Pregnant or Want to be Pregnant	0	0	2	0	2
Relocating or Moving	0	1	0	0	1
Total	9	11	5	3	28*

* Respondents were allowed to give more than one response.

PROGRAM CONCERNS

TABLE LIV

PROBLEMS WITH PHYSICAL SITE

	1976	1977	1978	1979	Total f	Total %
Yes	5	5	2	2	14	60
No	3	3	2	1	9	40
Total	8	8	4	3	23	100

TABLE LV

SERVICES YOU NOW HAVE

	1976	1977	1978	1979	Total f
Child Care	4	4	2	0	10
Welfare	0	1	1	0	2
Employment Counseling	0	2	0	0	2
Babysitting Service	0	3	4	0	7
Educational Counseling	0	0	2	0	2
Parent Education	1	1	2	1	5
Group Meetings With Other Mothers	0	2	1	1	4
Personal Counseling	0	1	1	0	2
Homemaker Services	0	0	0	0	0
Health Care	3	4	2	2	11
Legal Counseling	1	1	0	0	2

TABLE LVI

SERVICES YOU DON'T NEED NOW

	1976	1977	1978	1979	Total f
Child Care	4	2	0	2	8
Welfare	8	6	1	3	18
Employment Counseling	6	5	3	0	14
Babysitting Service	7	2	0	0	9
Educational Counseling	5	3	1	1	10
Parent Education	6	6	1	1	14
Group Meetings With Other Mothers	7	3	2	1	13
Personal Counseling	7	7	3	1	18
Homemaker Services	8	8	4	3	23
Health Care	3	3	0	2	8
Legal Counseling	6	5	2	3	16

TABLE LVII

RECOMMENDATION OF TEEN MOTHER PROGRAM

	1976	1977	1978	1979	Total f	Total %
Yes	7	8	4	3	22	95.7
No	0	0	0	0	0	
Data Missing	1	0	0	0	1	4.3
Total	8	8	4	3	23	100

TABLE LVIII

HAVE YOU RECOMMENDED THE TMP
TO A PREGNANT FRIEND?

	1976	1977	1978	1979	Total f	Total %
Yes	3	5	4	0	12	52.2
No	5	3	0	3	11	47.8
Total	8	8	4	3	23	100